SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: CRITICAL ILLNESS PRODUCT	SERFF Tr Num: ANTX-127031871	State: Arkansas
TOI: H07I Individual Health - Specified Disease - - Limited Benefit	SERFF Status: Closed-Approved-Closed	State Tr Num: 48677
Sub-TOI: H07I.001 Critical Illness	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: Sherry Wiegman	Disposition Date: 05/05/2011
	Date Submitted: 05/04/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: CRITICAL ILLNESS PRODUCT	Status of Filing in Domicile: Pending
Project Number: CRITICAL ILLNESS PRODUCT	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 05/05/2011
	State Status Changed: 05/05/2011
Deemer Date:	Created By: Sherry Wiegman
Submitted By: Sherry Wiegman	Corresponding Filing Tracking Number:

Filing Description:

Attached for your review and consideration is a new individual critical illness policy, rates and related forms. This is a new submission that does not replace any previously approved forms.

This product is an individual critical illness plan that provides an indemnity lump sum cash benefit payment when a covered person experiences a covered critical illness. Amounts are chosen by the applicant at the time of application.

To provide additional coverage, an optional Mortgage Protection Benefit Rider is available that provides a lump sum monthly cash benefit payment when a covered person experiences a covered critical illness that results in total disability.

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

This product will be sold to individual applicants from ages 18 – 75 through licensed producers.

The variable material shown in the policy reflects the benefit levels selected and insured specific information. The variable language or amounts on final printed forms will be no more restrictive than
that which is reflected in the enclosed forms.

We trust this information is complete and look forward to receiving your favorable reply. Please contact me should you feel additional information is needed or if I can be of assistance.

Company and Contact

Filing Contact Information

Sherry Wiegman, Sr. Compliance Analyst	sherry.wiegman@anico.com
One Moody Plaza, SSH MP, Ste. 200	281-538-4842 [Phone]
Galveston, TX 77550	409-766-2950 [FAX]

Filing Company Information

Standard Life and Accident Insurance Company	CoCode: 86355	State of Domicile: Texas
One Moody Plaza, SSH MP, Ste. 200	Group Code: 408	Company Type: Health Insurance
Galveston, TX 77550	Group Name:	State ID Number:
(281) 538-4842 ext. [Phone]	FEIN Number: 73-0994234	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	$100.00	05/04/2011	47253054
Standard Life and Accident Insurance Company	$200.00	05/05/2011	47278198

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/05/2011	05/05/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	05/05/2011	05/05/2011	Sherry Wiegman	05/05/2011	05/05/2011
Pending Industry Response	Rosalind Minor	05/05/2011	05/05/2011	Sherry Wiegman	05/05/2011	05/05/2011

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Disposition

Disposition Date: 05/05/2011
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Standard Life and Accident Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PREVIOUSLY APPROVED DUPLICATION NOTICE	Approved-Closed	Yes
Form	Application - Full Underwriting	Approved-Closed	Yes
Form	Application - Simplified Underwriting	Approved-Closed	Yes
Form *(revised)*	Critical Illness Policy	Approved-Closed	Yes
Form	Critical Illness Policy	Approved-Closed	Yes
Form	Optional Mortgage Protection Rider	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Policy Notice	Approved-Closed	Yes
Rate	Critical Illness Policy	Approved-Closed	Yes
Rate	Mortgage Protection Rider	Approved-Closed	Yes

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
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Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/05/2011
Submitted Date	05/05/2011
Respond By Date	06/06/2011

Dear Sherry Wiegman,

This will acknowledge receipt of the captioned filing.

Objection 1

- Critical Illness Policy, SLA-CI11-AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishong proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/05/2011
Submitted Date	05/05/2011

Dear Rosalind Minor,

Comments:
We have completed the review of your request for revisions.

Response 1

Comments: We have revised our continuation of handicapped provision in accordance with the referenced laws.

Related Objection 1

Applies To:

- Critical Illness Policy, SLA-CI11-AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishong proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Critical Illness Policy	SLA-CI11-AR		Policy/Contract/Fraternal Certificate	Initial		50.100	AR POLICY SLA-CI11 CRITICAL ILLNESS

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

					POLICY R Nonmkd.pdf
Previous Version					
Critical Illness Policy	*SLA-CI11-AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*50.100*	AR POLICY SLA-CI11 CRITICAL ILLNESS POLICY R Nonmkd.pdf

No Rate/Rule Schedule items changed.

We trust this information is complete and look forward to receiving your favorable reply. Thank you for your continued review.

Sincerely,
Sherry Wiegman

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/05/2011
Submitted Date	05/05/2011
Respond By Date	

Dear Sherry Wiegman,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application - Full Underwriting, SL-CIINDAR2 (Form)
- Application - Simplified Underwriting, SL-CIINDSIAR2 (Form)
- Critical Illness Policy, SLA-CI11-AR (Form)
- Optional Mortgage Protection Rider, SLA-CIMP11 (Form)
- Outline of Coverage, SLA-CI11OOC2 (Form)
- Policy Notice, SL-IN4CI-AR (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $300.00. Please submit an additional $200.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
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Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/05/2011
Submitted Date	05/05/2011

Dear Rosalind Minor,

Comments:
We have completed the review of your request.

Response 1

Comments: We have submitted the requested additional $200.00.

Related Objection 1

Applies To:

- Application - Full Underwriting, SL-CIINDAR2 (Form)
- Application - Simplified Underwriting, SL-CIINDSIAR2 (Form)
- Critical Illness Policy, SLA-CI11-AR (Form)
- Optional Mortgage Protection Rider, SLA-CIMP11 (Form)
- Outline of Coverage, SLA-CI11OOC2 (Form)
- Policy Notice, SL-IN4CI-AR (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $300.00. Please submit an additional $200.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your continued review.

Sincerely,
Sherry Wiegman

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Form Schedule

Lead Form Number: SLA-CIII

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/05/2011	SL-CIINDAR2	Application/Enrollment Form	Application - Full Underwriting	Initial		50.100	AR SL-CIINDAR2 APPLICATION.pdf
Approved-Closed 05/05/2011	SL-CIINDSIAR2	Application/Enrollment Form	Application - Simplified Underwriting	Initial		50.100	AR SL-CIINDSIAR2 APPLICATION.pdf
Approved-Closed 05/05/2011	SLA-CI11-AR	Policy/Contract/Fraternal Certificate	Critical Illness Policy	Initial		50.100	AR POLICY SLA-CI11 CRITICAL ILLNESS POLICY R Nonmkd.pdf
Approved-Closed 05/05/2011	SLA-CIMP11	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Optional Mortgage Protection Rider	Initial		50.100	SLA-CIMP11 MORTGAGE PROTECTION RIDER GENERIC.pdf
Approved-Closed 05/05/2011	SLA-CI11OOC2	Outline of Coverage	Outline of Coverage	Initial		50.100	OUTLINE SLA-CI11OOC2 - OUTLINE - GENERIC.pdf
Approved-Closed	SL-IN4CI-AR	Other	Policy Notice	Initial		50.100	AR IMPORTANT

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

05/05/2011

NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION.pdf

Standard Life
A Member of the American National Family of Companies

Standard Life and Accident Insurance Company
Mailing Address: P.O. Box 696870, San Antonio, TX 78269
888.350.1488

CRITICAL ILLNESS INSURANCE APPLICATION

Please Print — Use Black Ink ❑ New Policy ❑ Reinstatement

SECTION A

1. Applicant _____ Date of Birth _____ Age ____ Sex ____ Height ____ Weight ____
Home Address _____ City _____ State ____ Zip _____
Phone (____) _____ Best time to call _____ ❑ a.m. ❑ p.m. Email _____
Social Security Number _____ Occupation _____
Billing Address (if different) _____ City _____ State ____ Zip _____

2. Please print the full name of all other Proposed Insureds (Use additional sheet and attach if needed).

Last, First, Middle Initial	Relationship	Sex M/F	Date of Birth Month, Day, Year	Age	Height (ft.-in.)	Weight (lbs.)	Occupation
	Spouse						

3. **BENEFIT AND PREMIUM DATA**

		Billable Premium
Applicant Benefit Amount:	$ _____	$ _____
Ages 65–70:	❑ $10,000 ❑ $15,000	$ _____
Ages 71–75:	❑ $10,000	$ _____
Spouse: (cannot be greater than the Applicant)	$ _____	$ _____
Child: (cannot be greater than the Applicant)	❑ $10,000 ❑ $15,000 ❑ $20,000 ❑ $25,000 ❑ $30,000	$ _____
Mortgage Protection Rider: (Applicant only–not available after age 65)	❑ $500 ❑ $1,000 ❑ $1,500	$ _____
Total Billable Premium:		$ _____

Billing Mode
❑ Annual
❑ Semi-Annual
❑ Quarterly
❑ Monthly PAC
❑ List Bill

4. Will any Critical Illness insurance be replaced with this policy? ..... ❑ **Yes** ❑ **No**
If Yes, which company? _____ Policy Number _____

SECTION B

5. Has the Applicant or any Proposed Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer or stroke? .. ❑ **Yes** ❑ **No**
If Yes, indicate family member, illness, age at onset of illness and, if applicable, age at death.

	Applicant		Spouse/Other Proposed Insured	
	Age if Living	Age at Death/Cause or Age at Diagnosis/Cause	Age if Living	Age at Death/Cause or Age at Diagnosis/Cause
Father				
Mother				
Sibling				

6. a. Has the Applicant used any form of tobacco within the past 12 months? ..... ❑ **Yes** ❑ **No**
b. Has the Spouse (if coverage applied for) used any form of tobacco within the past 12 months?..... ❑ **Yes** ❑ **No**
7. Has the Applicant or any Proposed Insured had a weight gain or loss of 10 pounds or more within the past 12 months? ..... ❑ **Yes** ❑ **No**
If Yes, provide name of Applicant or any Proposed Insured and details of weight change. ❑ Gain ❑ Loss
Name of Applicant or any Proposed Insured _____ Cause of Weight Gain/Loss _____
8. Does the Applicant or any Proposed Insured use a cane, walker, motorized vehicle, wheelchair or require mobility assistance by another person?..... ❑ **Yes** ❑ **No**
If Yes, provide details: _____
9. Has the Applicant or any Proposed Insured within the past 5 years been charged with a driving while impaired violation (alcohol, drugs, other), had driver's license revoked or suspended, or within the last 24 months received 3 or more citations for moving violations?..... ❑ **Yes** ❑ **No**
If Yes, provide driver's license number and state of issue: _____
10. Does the Applicant or any Proposed Insured intend to travel or reside outside the U.S. for more than 3 months during the next 12 months?..... ❑ **Yes** ❑ **No**
11. Within the past 5 years has the Applicant or any Proposed Insured:
a. had an application for insurance declined, rated or postponed?..... ❑ **Yes** ❑ **No**
b. flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so? ..... ❑ **Yes** ❑ **No**
c. engaged in boxing, scuba diving, parachuting, racing or any other hazardous sport or have intentions to do so? ..... ❑ **Yes** ❑ **No**
d. sought or received advice, counseling, or treatment by a physician for the use of alcohol or drugs including prescription drugs?. ❑ **Yes** ❑ **No**
e. used cocaine or marijuana or any other drug except as legally prescribed by a physician? ..... ❑ **Yes** ❑ **No**

SECTION B *(Continued)*

Please provide details for questions 10 and 11a through 11e.

Question	Name	Details

12. Has the Applicant or any Proposed Insured ever received treatment for, been diagnosed with, been advised to have diagnostic tests for, or is now being treated for any of the following:
    a. abnormal blood pressure, chest pain, coronary artery disease, abnormal ECG, elevated cholesterol, stroke, transient ischemic attack (TIA), peripheral vascular disease or any other disorder or disease or the heart, blood vessels or of the cerebrovascular system? ..... ❑ **Yes** ❑ **No**
    b. cancer, tumor, polyps, basal or squamous cell carcinoma, abnormal moles, or lesions, dysplastic nevi, malignant melanoma, abnormal PAP Smear, abnormal PSA test, abnormal mammogram, fibrocystic breast disease with history of breast biopsy, recurrent tumors or unexplained tumors or growth? ..... ❑ **Yes** ❑ **No**
    c. diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder? ..... ❑ **Yes** ❑ **No**
    d. any ear, nose, throat, lung, or any other respiratory disorder? ..... ❑ **Yes** ❑ **No**
    e. any disorder of the stomach, intestines, rectum, liver or pancreas? ..... ❑ **Yes** ❑ **No**
    f. any injury to or disease of the bones, muscles, joints, eyes, or skin? ..... ❑ **Yes** ❑ **No**
    g. epilepsy, seizures, brain disorder, tremor, multiple sclerosis, paralysis, Parkinson's, Alzheimer's or any other disease or disorder of the nervous system? ..... ❑ **Yes** ❑ **No**
    h. anxiety, depression, or an emotional, behavioral, mental or nervous disorder? ..... ❑ **Yes** ❑ **No**
    i. any disease or disorder of the kidney, bladder, or genital organs or system? ..... ❑ **Yes** ❑ **No**
    j. AIDS (Acquired Immune Deficiency syndrome), ARC (Aids Related Complex), positive HIV (Human Immunodeficiency Virus) test, or any other immunological disorder? ..... ❑ **Yes** ❑ **No**
13. Other than as stated above, has the Applicant or any Proposed Insured, within the past 5 years:
    a. consulted, received treatment or advice from, been prescribed medication by any other physician? ..... ❑ **Yes** ❑ **No**
    b. had any abnormal diagnostic or screening tests? ..... ❑ **Yes** ❑ **No**
    c. been aware of any symptoms for which a physician has not yet been consulted or been advised to have any diagnostic/screening or tests or procedures which have not yet been performed? ..... ❑ **Yes** ❑ **No**
14. Please list name and address of family/Primary Care Physician(s), reason and date last seen for each Applicant or any Proposed Insured including details for each Yes answer to questions 12 and 13.

Name of Applicant or any Proposed Insured	Condition	Medication	Date(s) of Treatment	Results	Name/Address of Physician

SECTION C

ATTENTION — After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I/we have received the *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare. I/We have also received an outline of coverage if required in my/our state.

FRAUD WARNING — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned has completed this application and represents that the answers and statements in Sections A and B on this application are true, complete, and correctly recorded to the best of my/our knowledge and belief; and agree they will be used to determine each Proposed Insured's eligibility for coverage applied for hereby. I/We understand and agree that: **1.** all statements and answers in this application and in any supplements or amendments to it are complete and true; **2.** any incorrect or incomplete information on this application may result in loss of coverage or claim denial; **3.** no insurance shall take effect unless a policy is issued (or if this application is made to change or reinstate an existing policy, unless the request is approved by the Company) and actually delivered to the Applicant and the first full premium paid during the lifetime and good health of all Proposed Insureds. I/We will notify and provide the Company with any evidence required by it to determine my/our future eligibility under the policy issued. If this application is taken over the phone, I/we agree that my/our electronic signature(s) serve(s) as my/our original signature(s).

I/We understand and agree that: 1. eligibility for the Plan does not constitute initial coverage under the Plan; and **2.** initial coverage under the Plan is subject to the Company's criteria.

This is a Limited Benefit Policy. Please review the policy carefully.

Date

Dated at City, State

Applicant's Signature

Spouse's Signature (if coverage is requested)

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I/We hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant or any Proposed Insured. It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I/We understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I/We understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I/We may refuse to sign this authorization and that my/our refusal to sign will affect my/our ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I/We, or my/our authorized representative, am/are entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I/We understand I/we may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I/We may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I/we agree that my/our electronic signature serves as my/our original signature.

Date	Dated at City, State
Applicant's Signature	Spouse's Signature (if coverage is requested)
Witness	Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other _____ .

AUTHORIZATION TO MY BANK

PREAUTHORIZED CHECK AUTHORIZATION

Attach Voided Check or Deposit Ticket Here and Sign Authorization

- ❑ **Checking**
- ❑ **Savings**

Bank Information

Name

City | State | Zip

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

Date Signed | ✓ Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number _____

Routing Number _____

AGENT STATEMENT

- As Agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? ..... ❑ **Yes** ❑ **No**
  If Yes, was a replacement form completed and a copy left with the Applicant? ..... ❑ **Yes** ❑ **No**
- As Agent, have you complied with state replacement regulations? ..... ❑ **Yes** ❑ **No**
- I have verified the Applicant's identity through a U.S. federal or state government-issued I.D. such as driver's license, government-issued I.D., passport, visa, etc. ..... ❑ **Yes** ❑ **No**

I have inquired about and have personal knowledge of the medical history of the Applicant and each Proposed Insured.

Agent's Name (please print) _____

Agent's Signature _____

Agent's Writing Number _____

Date Signed _____

Phone (_____) _____

Fax (_____) _____

Email _____

Premium Quoted: $_____

❑ **Premium collected with Application.**

❑ **Initial premium is to be drafted.**

Mail Policy to: ❑ Insured ❑ Agent

Special Request: _____

Standard Life
A Member of the American National Family of Companies

Standard Life and Accident Insurance Company
Mailing Address: P.O. Box 696870, San Antonio, TX 78269
888.350.1488

CRITICAL ILLNESS INSURANCE APPLICATION

Please Print — Use Black Ink ❑ New Policy ❑ Reinstatement

SECTION A

1. Applicant _____ Date of Birth _____ Age ____ Sex ____ Height ____ Weight ____

Home Address _____ City _____ State ____ Zip _____

Phone (____) _____ Best time to call _____ ❑ a.m. ❑ p.m. Email _____

Social Security Number _____ Occupation _____

Billing Address (if different) _____ City _____ State ____ Zip _____

2. Please print the full name of all other Proposed Insureds (Use additional sheet and attach if needed).

Last, First, Middle Initial	Relationship	Sex M/F	Date of Birth Month, Day, Year	Age	Height (ft.-in.)	Weight (lbs.)	Occupation
	Spouse						

3. **BENEFIT AND PREMIUM DATA** — **Billable Premium**

Applicant Benefit Amount:	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000	
	❑ $35,000	❑ $40,000	❑ $45,000	❑ $50,000		$ _____
Ages 65–70:	❑ $10,000	❑ $15,000				$ _____
Ages 71–75:	❑ $10,000					$ _____
Spouse: (cannot be greater than the Applicant)	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000	
	❑ $35,000	❑ $40,000	❑ $45,000	❑ $50,000		$ _____
Child: (cannot be greater than the Applicant)	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000	$ _____
Mortgage Protection Rider: (Applicant only–not available after age 65)	❑ $500	❑ $1,000	❑ $1,500			$ _____
Total Billable Premium:						$ _____

Billing Mode
❑ Annual
❑ Semi-Annual
❑ Quarterly
❑ Monthly PAC
❑ List Bill

4. Will any Critical Illness insurance be replaced with this policy? ..... ❑ **Yes** ❑ **No**
If Yes, which company? _____ Policy Number _____

SECTION B (This plan cannot be issued to any person who answers Yes to questions 7, 8 or 9.)

5. Has the Applicant or any Proposed Insured had two or more biological parents and/or siblings, either living or deceased, diagnosed with or die from one of the same conditions listed below. If Yes, check all that apply and list name of Proposed Insured:

a. Prior to age 60		
❑ Cancer _____	❑ Heart Disease _____	❑ Stroke _____
❑ Diabetes _____	❑ Kidney Disease _____	
b. Prior to age 75		
❑ Alzheimer's _____	❑ Colorectal Cancer _____	❑ Senile Dementia _____

6. a. Has the Applicant used any form of tobacco within the past 12 months? ..... ❑ **Yes** ❑ **No**
b. Has the Spouse (if coverage applied for) used any form of tobacco within the past 12 months? ..... ❑ **Yes** ❑ **No**

7. In the past 2 years, has the Applicant or any Proposed Insured been informed by a physician of any abnormal test results or been advised to have any diagnostic/screening tests or procedures which have not yet been performed? ..... ❑ **Yes** ❑ **No**
If Yes, list name of Applicant or Proposed Insured: _____

8. Does the Applicant or any Proposed Insured use a cane, walker, motorized vehicle, wheelchair or require mobility assistance by another person? ..... ❑ **Yes** ❑ **No**
If Yes, list name of Applicant or Proposed Insured: _____

SECTION B *(Continued)*

9. Has the Applicant or Proposed Insured ever been diagnosed with, advised by a physician to have diagnostic tests for, been treated for in the past or is currently being treated for any of the following? ..... ❑ **Yes** ❑ **No**

If Yes, check all that apply and list name of Applicant or Proposed Insured:

- ❑ Alcohol or Drug Abuse _____
- ❑ Alzheimer's _____
- ❑ Angioplasty _____
- ❑ Aortic Surgery _____
- ❑ Bone Marrow Transplant _____
- ❑ Cancer (excluding non-invasive, non-melanoma Skin Cancer) _____
- ❑ Coronary Artery Bypass Surgery _____
- ❑ Diabetes _____
- ❑ End Stage Renal Disease _____
- ❑ Heart Attack _____
- ❑ Heart Valve Surgery _____
- ❑ Hepatitis B, C or Carrier _____
- ❑ Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) _____
- ❑ Leukemia _____
- ❑ Liver Cirrhosis _____
- ❑ Major Organ Failure or Transplant _____
- ❑ Multiple Sclerosis _____
- ❑ Senile Dementia _____
- ❑ Stroke _____
- ❑ Transient Ischemic Attack (TIA) _____

10. In the past 5 years, has the Applicant or any Proposed Insured been diagnosed with or treated for any of the following conditions? ❑ **Yes** ❑ **No**

If Yes, check all that apply:

- ❑ Abnormal Mammogram
- ❑ Abnormal Moles or Lesions
- ❑ Abnormal Pap Smear
- ❑ Abnormal Prostate-Specific Antigen (PSA)
- ❑ Basal or Squamous Cell Carcinoma
- ❑ Crohn's Disease (except irritable bowel disease or mucus colitis)
- ❑ Disease or disorder of the heart or blood vessels
- ❑ Disease of the nervous system (except non-chronic shingles)
- ❑ Dysplastic Nevi
- ❑ Fibrocystic Breast Disease (with history of biopsy)
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hyperlipidemia
- ❑ Kidney Disease (except non-chronic kidney stones or infection)
- ❑ Liver Disease
- ❑ Lung Disease (except asthma that has never required hospitalization and non-chronic bronchitis)
- ❑ Pancreas Disorder
- ❑ Polyps
- ❑ Pre-cancerous Lesions/ Tumors
- ❑ Recurrent Breast Tumors
- ❑ Recurrent Human Papilloma Virus (HPV)
- ❑ Skin Cancer
- ❑ Ulcerative Colitis
- ❑ Unexplained Tumors/ Growth

Complete the following for each condition checked in question 10.

Name of Applicant or Proposed Insured	Condition	Medication	Date(s) of Treatment	Results	Name/Address of Physician

SECTION C

ATTENTION — After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I/we have received the *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare. I/We have also received an outline of coverage if required in my/our state.

FRAUD WARNING — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned has completed this application and represents that the answers and statements in Sections A and B on this application are true, complete, and correctly recorded to the best of my/our knowledge and belief; and agree they will be used to determine each Proposed Insured's eligibility for coverage applied for hereby. I/We understand and agree that: **1.** all statements and answers in this application and in any supplements or amendments to it are complete and true; **2.** any incorrect or incomplete information on this application may result in loss of coverage or claim denial; **3.** no insurance shall take effect unless a policy is issued (or if this application is made to change or reinstate an existing policy, unless the request is approved by the Company) and actually delivered to the Applicant and the first full premium paid during the lifetime and good health of all Proposed Insureds. I/We will notify and provide the Company with any evidence required by it to determine my/our future eligibility under the policy issued. If this application is taken over the phone, I/we agree that my/our electronic signature(s) serve(s) as my/our original signature(s).

I/We understand and agree that: 1. eligibility for the Plan does not constitute initial coverage under the Plan; and **2.** initial coverage under the Plan is subject to the Company's criteria.

This is a Limited Benefit Policy. Please review the policy carefully.

Date _____ Dated at City, State _____

Applicant's Signature _____ Spouse's Signature (if coverage is requested) _____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I/We hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant or any Proposed Insured. It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I/We understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I/We understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I/We may refuse to sign this authorization and that my/our refusal to sign will affect my/our ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I/We, or my/our authorized representative, am/are entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I/We understand I/we may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I/We may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I/we agree that my/our electronic signature serves as my/our original signature.

Date	Dated at City, State
Applicant's Signature	Spouse's Signature (if coverage is requested)
Witness	Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other _____ .

AUTHORIZATION TO MY BANK

PREAUTHORIZED CHECK AUTHORIZATION

Attach Voided Check or Deposit Ticket Here and Sign Authorization

- ❑ **Checking**
- ❑ **Savings**

Bank Information

Name

City | State | Zip

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

Date Signed | ✓ Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number _____

Routing Number _____

AGENT STATEMENT

- As Agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? ..... ❑ **Yes** ❑ **No**
  If Yes, was a replacement form completed and a copy left with the Applicant? ..... ❑ **Yes** ❑ **No**
- As Agent, have you complied with state replacement regulations? ..... ❑ **Yes** ❑ **No**
- I have verified the Applicant's identity through a U.S. federal or state government-issued I.D. such as driver's license, government-issued I.D., passport, visa, etc. ..... ❑ **Yes** ❑ **No**

I have inquired about and have personal knowledge of the medical history of the Applicant and each Proposed Insured.

Agent's Name (please print) _____

Agent's Signature _____

Agent's Writing Number _____

Date Signed _____

Phone (_____) _____

Fax (_____) _____

Email _____

Premium Quoted: $_____

❑ **Premium collected with Application.**

❑ **Initial premium is to be drafted.**

Mail Policy to: ❑ Insured ❑ Agent

Special Request: _____

Standard Life and Accident Insurance Company

A Member of the American National Family of Companies
Home Office: One Moody Plaza, Galveston, Texas, 77550
Toll-Free Telephone Number: 1-888-350-1488
(A Stock Insurance Company hereafter referred to as "Standard Life", "We", "Us", "Our" or "the Company")

CRITICAL ILLNESS INSURANCE POLICY

We pay benefits in accordance with all the terms and conditions of this Policy when a Covered Person is Diagnosed with a Critical Illness. This Policy is a legal contract of insurance. This Policy is non-participating. **THIS POLICY PROVIDES NO BENEFITS OTHER THAN FOR A CRITICAL ILLNESS. READ IT CAREFULLY.**

CONSIDERATION - This Policy is issued in consideration of the statements made in the Application and payment of the Initial Premium. Coverage is not provided until the first full premium is paid. The first premium pays for the Initial Term of coverage. The Initial Term of coverage begins at 12:01 a.m. on the Policy Date shown in the Policy Schedule of Benefits. Coverage is continued in accordance with all of the provisions of this Policy.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION - You should carefully read Your Application and all documents attached to this Policy. Omissions or misstatements in Your Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage. Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Policy if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Application.

YOUR 30 DAY RIGHT TO EXAMINE POLICY. Within 30 days after You get this Policy, You may return it in person or by regular mail to the Company, its agency office or the agent who sold it to You, if for any reason You decide You do not want it. The Company will promptly return Your premium to You and then You and the Company will be in the same position as if a Policy had never been issued.

GUARANTEED RENEWABLE AT THE OPTION OF THE POLICYHOLDER – SUBJECT TO PREMIUM IN EFFECT AT THE TIME OF RENEWAL. You have the right to continue this Policy in force subject to the termination provisions and Your continued payment of premium in accordance with all the provisions of this Policy.

PREMIUMS ARE SUBJECT TO CHANGE - Please refer to the section titled **PREMIUMS**.

This Policy is signed below on behalf of Standard Life by its duly authorized officers.

Secretary

President

THIS IS A LIMITED BENEFIT HEALTH INSURANCE POLICY.

POLICIES OF THIS CATEGORY ARE DESIGNED TO PROVIDE LIMITED OR SUPPLEMENTAL BENEFITS. THIS POLICY DOES NOT PROVIDE FOR REIMBURSEMENT OF ANY MEDICAL EXPENSES. BENEFITS PROVIDED ARE A SUPPLEMENT, AND NOT INTENDED AS A SUBSTITUTE FOR MEDICAL EXPENSE COVERAGE OR DISABILITY INSURANCE. PLEASE READ THIS POLICY CAREFULLY!

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, You should review the *Guide To Health Insurance For People With Medicare* available from the Company.

TABLE OF CONTENTS

POLICY SCHEDULE

BENEFIT AMOUNTS PER COVERED PERSON

[BENEFITS OTHERWISE PAYABLE ARE REDUCED 50% ON THE LATER OF A COVERED PERSON'S AGE 70 OR HIS/HER 5TH POLICY ANNIVERSARY.]

POLICYHOLDER –
INITIAL BENEFIT AMOUNT – [$10,000 - $500,000]
MAXIMUM BENEFIT AMOUNT – 3 TIMES THE INITIAL BENEFIT AMOUNT

[SPOUSE -
INITIAL BENEFIT AMOUNT – [$10,000 - $500,000]
MAXIMUM BENEFIT AMOUNT – 3 TIMES THE INITIAL BENEFIT AMOUNT]

[CHILD –
INITIAL BENEFIT AMOUNT – [$10,000 - $500,000]
MAXIMUM BENEFIT AMOUNT – 3 TIMES THE INITIAL BENEFIT AMOUNT]

	BENEFIT PERCENTAGE
Category 1 Critical Illnesses -	
• Invasive Cancer (Diagnosis more than [30, 90] days after Policy Date)	100%
• Invasive Cancer (Diagnosis during the first [30, 90] days of in force coverage)	10%
• Cancer In Situ (Diagnosis more than [30, 90] days after Policy Date)	25%
• Cancer In Situ (Diagnosis during the first [30, 90] days of in force coverage)	2.5%
Category 2 Critical Illnesses -	
• Heart Attack	100%
• Stroke	100%
• Heart Transplant or Combination Heart and Other Major Organ Transplant	100%
• Coronary Artery Bypass Surgery	25%
• Angioplasty	25%
• Aortic Surgery	25%
• Heart Valve Replacement/Repair Surgery	25%
Category 3 Critical Illnesses -	
• Major Organ Transplant, not covered in Category 2	100%
• Coma	100%
• Paralysis	100%
• End-Stage Renal Failure	100%

OPTIONAL BENEFITS: [**None**] [**Mortgage Protection Benefit** – [$500 - $1500]
Maximum Rider Benefit - [$6,000 - $18,000]]

POLICY NUMBER – [xxxxxxxxxxxxx]

POLICY DATE – [MAY 1, 2010]

STATE OF ISSUE – ARKANSAS

INITIAL PREMIUM – [$xxxxx] A $25 annual policy fee is calculated into the annual premium.

INITIAL TERM – [ANNUAL, SEMI-ANNUAL, QUARTERLY, MONTHLY]

COVERED PERSONS	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**
[JJ ANICO	POLICYHOLDER	69	04/22/1942]
[GG ANICO	SPOUSE	24	04/16/1986]

[INTENTIONALLY LEFT BLANK]

DEFINITIONS

AGE means a Covered Person's age on his/her last birthday.

ANGIOPLASTY means the actual undergoing of a percutaneous transluminal angioplasty deemed Medically Necessary to correct a narrowing or blockage of one or more coronary arteries. A Physician, board-certified as a Cardiologist, must perform the Procedure. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

AORTIC SURGERY means the actual undergoing of surgery for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. The surgery must be deemed Medically Necessary and performed by a Physician, board-certified as a cardiovascular surgeon, thoracic surgeon, or vascular surgeon. Aorta is limited to the thoracic and abdominal aorta, but not its branches.

CANCER IN SITU means a Diagnosis of Cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Cancer in Situ includes

1. early prostate cancer Diagnosed as T1N0M0 or equivalent staging; and
2. melanoma not invading the dermis.

Cancer in Situ does not include

1. other skin malignancies; or
2. pre-malignant lesions (such as intraepithelial neoplasia); or
3. benign tumors or polyps.

Cancer in Situ must be Diagnosed pursuant to a Pathological or Clinical Diagnosis.

CLINICAL DIAGNOSIS means a Diagnosis of Invasive Cancer or Cancer In Situ based on the study of symptoms and Diagnostic test results. We will accept a Clinical Diagnosis of Cancer only if the following conditions are met:

1. a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
2. there is medical evidence to support the Diagnosis; and
3. a Physician is treating the Covered Person for Invasive Cancer and/or Cancer In Situ.

CLOSE RELATIVE means anyone related to a Covered Person by blood, marriage, or adoption; or a court appointed representative.

COMA means the diagnosis, by a Legally Qualified Physician board-certified as a Neurologist, that a Covered Person is in a state of unconsciousness:

1. from which he/she cannot be aroused;
2. in which external stimulation will produce no more than primitive avoidance reflexes; and
3. such state has persisted continuously for at least 96 hours.

No benefit is payable for Coma if Coma is the result of a Critical Illness for which benefits are otherwise payable under this Policy.

COVERED PERSON means each person named as a Covered Person on the Policy Schedule whose coverage under this Policy has not terminated.

CORONARY BYPASS SURGERY means the actual undergoing of coronary artery bypass surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease deemed Medically Necessary to correct a narrowing or blockage of one or more coronary arteries. The Procedure must be performed by a Physician, board-certified as a cardiovascular surgeon or thoracic surgeon. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

CRITICAL ILLNESS means any of the medical conditions or procedures, shown in the Policy Schedule, that is first Diagnosed or first performed as the result of a Diagnosis, each made after the respective Covered Person's Policy Date.

DATE OF DIAGNOSIS means the date the Diagnosis is established by a Physician, through the use of clinical and/or laboratory findings as supported by the Covered Person's medical records. For a procedure, it is the date the Covered Person undergoes the procedure.

DEPENDENT means Policyholder's family as follows:
1. The lawful Spouse; or
2. Unmarried children (whether natural, adopted or stepchildren) under age 26; or
3. Unmarried children for whom the Policyholder is required to provide insurance under a medical support order or an order enforceable by a court; or
4. Unmarried children under the age of 26 that the Policyholder is seeking to adopt through an appropriate legal action before a court of competent jurisdiction over matters of adoption.

DIAGNOSIS - The definitive establishment by a Physician of the Critical Illness through the use of clinical and/or laboratory findings.

END-STAGE RENAL FAILURE means the chronic and irreversible failure of both of a Covered Person's kidneys, which requires the Covered Person to undergo periodic and ongoing dialysis. The Diagnosis must be made by a Physician.

FIRST OCCUR(S)/FIRST OCCURRING/FIRST OCCURRENCE means the occurrence, Diagnosis, or procedure is the first time ever in the Covered Person's lifetime that he/she has experienced such Critical Illness, been Diagnosed with that specific condition included as a Critical Illness, or undergone a specific procedure included as a Critical Illness.

HEART ATTACK means an Acute Myocardial Infarction resulting in:

1. the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries; and
2. resulting in the loss of the normal function of the heart.

The Diagnosis must be made by a Physician and based on both:

1. new clinical presentation and electrocardiographic changes consistent with an evolving heart attack; and
2. serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

Established (old) Myocardial Infarction is excluded.

HEART VALVE REPLACEMENT/REPAIR SURGERY means the actual undergoing of open heart surgery to replace or repair one or more valves. The surgery must be deemed Medically Necessary and performed by a Physician, board-certified as a cardiovascular surgeon or thoracic surgeon.

INVASIVE CANCER means a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue through the basement membrane or capsule. "Invasive Cancer" includes, but shall not be limited to any form of:

1. Leukemia;
2. Lymphoma; or
3. Multiple Myeloma

The following are <u>not</u> "Invasive Cancer":
1. pre-malignant lesions (such as intraepithelial neoplasia); or
2. benign tumors or polyps; or
3. early prostate cancer Diagnosed as T1N0M0 or equivalent staging; or
4. Cancer in Situ; or
5. any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

Invasive Cancer must be Diagnosed by a by a Physician, board-certified as a pathologist pursuant to a Pathological or Clinical Diagnosis.

LIMITING AGE for Your children is 26 years of age.

MAJOR ORGAN means a Covered Person's entire liver, kidney, lung, heart, small intestine, pancreas, pancreas-kidney, bone marrow, or stem-cells. <u>No</u> other organ or system is included.

MAJOR ORGAN TRANSPLANT means the placement of an entire Major Organ in a Covered Person, where such Major Organ:

1. originates in a person other than such Covered Person;
2. is somewhat independent from all other parts of the human body; and
3. performs a special or unique function.

An Major Organ Transplant does not include the placement of a mechanical or man-made device or substance which is intended to serve as a substitute for or aid in the performance of the failed Major Organ; nor does it include Major Organ parts such as valves, ducts, arteries, and any other part of a Major Organ, which in and of itself provides no life sustaining purpose. For purposes of this definition, a Major Organ Transplant is considered to have occurred on the date a Covered Person is added to the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP) transplant list.

MAXIMUM BENEFIT AMOUNT means the eligible total of Benefit Payments for all Critical Illnesses as stated in the Policy Schedule, including all components of the Multiple Payment Benefit provision. **RECURRENCE BENEFIT PAYMENTS ARE NOT INCLUDED IN THE MAXIMUM BENEFIT AMOUNT.**

MEDICALLY NECESSARY means that, based on generally accepted current medical practice, a service is necessary and appropriate for the Diagnosis or treatment of a Critical Illness. We do not consider a service Medically Necessary if:

1. It is provided only as a convenience to the Covered Person or provider; or
2. It is not appropriate treatment for the Covered Person's Diagnosis or symptoms;
3. It exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment.

PATHOLOGICAL DIAGNOSIS means Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.

PARALYSIS means a Covered Person's complete and permanent loss of use, not including amputation. of two or more limbs through neurological injury for a continuous period of at least 180 days, confirmed by a Legally Qualified Physician board-certified as a Neurologist. No benefit is payable for Paralysis if Paralysis is the result of a Critical Illness for which benefits are otherwise payable under this Policy.

PHYSICIAN means a person, other than You, a Close Relative, or a business or professional partner who is:

1. duly licensed to practice medicine in the jurisdiction where the Diagnosis is made, or the procedure performed where such jurisdiction is a continuing member of the United States of America or a territory within the jurisdiction of the United States of America (embassies, military zones, and similarly designated non-domestic extensions of the United States government are not included); and
2. acting within the scope of his/her license.

POLICY DATE means the date, shown in Your Policy Schedule, when coverage begins for the Covered Persons originally covered under this Policy. We use the Policy Date to determine the anniversary dates of coverage under this Policy. It also refers, separately, to the date We add a Covered Person to this Policy or when any change in coverage occurs.

POLICYHOLDER means You, the Applicant named in the attached Application, any successor thereof, or any person named to assume ownership privileges under this Policy after the original Policyholder's death. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

PREEXISTING CONDITION means a medical condition relating to a Critical Illness, not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Physician within 12 months before the Covered Person's Policy Date; or (2) that would have caused a reasonably prudent person to seek medical Diagnosis or treatment within 12 months before his/her Policy Date. Critical Illness related to such a medical condition is not covered within 12 months of a Covered Person's Policy Date

STROKE means any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent. Transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded. The Diagnosis must be made by a Physician.

US, WE, OUR or THE COMPANY means Standard Life and Accident Insurance Company (SLAICO).

YOU or YOUR means the Applicant, named in the attached Application who is the Policyholder.

BENEFIT

In accordance with all the terms and conditions of this Policy and upon Diagnosis providing evidence that a Covered Person has a Critical Illness First Occurring after the Covered Person's Policy Date, the Company will pay You the percentage of the Initial Benefit Amount shown in the Policy Schedule for the Diagnosed Critical Illness.

Benefits will be paid to You in a lump-sum. Benefits paid on behalf of each Covered Person will not exceed the Maximum Benefit Amount. Upon payment of the Maximum Benefit Amount on behalf of a Covered Person, coverage for such Covered Person will terminate.

Benefits are payable under this Policy for a Covered Person from each of the Benefit Categories shown in the Policy Schedule when such Covered Person is Diagnosed with a Critical Illness. However, the total benefit payable under each Category will not exceed the Initial Benefit Amount, also shown in the Policy Schedule.

If the first benefit paid from a Category is a 100% benefit, no further benefits for other Critical Illnesses under the same Category will be paid. If the first benefit paid under a Category is not a 100% benefit, subsequent benefits payable under the same Category will be paid as a percentage of the Initial Benefit Amount until the sum of all payments from that same Category equals the Initial Benefit Amount. Then, no further benefits will be paid under that Category, except as provided under the Recurrence Benefit.

RECURRENCE BENEFIT – In addition to all other benefits otherwise paid under this Policy, if a Category 2 & 3 Critical Illness for which a 100% benefit has been previously paid recurs more than 18 months following its First Occurrence and prior to the total paid benefits exceeding the Maximum Benefit Amount, We will pay a benefit of 25% of the Initial Benefit Amount paid for up to two (2) such recurrences.

However, for any benefit to be paid under this provision, coverage under this Policy must be in effect for the Covered Person on the date recurrence is Diagnosed and the Covered Person must have been treatment free (except for maintenance medication and follow-up visits) for 12 months prior to the recurrence.

REDUCED BENEFIT PERIOD - If a Category 1 Critical Illness is Diagnosed within [30 – 90] days of a Covered Person's Policy Date, the following Critical Illnesses will be limited to the respective maximum benefit percentage shown below. In addition, no other benefits for Category 1 Critical Illnesses will be paid.

Invasive Cancer - 10%
Cancer In Situ - 2.5%

ADDITIONAL BENEFIT – If benefits under this Policy are paid when You have been Diagnosed as having any of the following Critical Illnesses: Invasive Cancer; Heart Attack; Stroke; Major Organ Failure; Coma; or Paralysis, more than 90 days after Your Policy Date, then an additional benefit equal to the value of 6 times the then current monthly premium for this Policy will be paid to You.

This Additional Benefit is provided only as the result of the First Occurrence of Your Critical Illness and does not apply to any claim made under the Recurrence Benefit or a claim made by any other Covered Person.

EXCEPTIONS and LIMITATIONS

[Benefits otherwise payable under the Policy are reduced 50% on the later of a Covered Person's Age 70 or his/her 5th Policy anniversary.]

Unless the Covered Person's Critical Illness First Occurs or is Diagnosed while coverage is in force under this Policy, no benefit will be payable.

No benefit is payable for Coma if Coma is the result of a Critical Illness for which benefits are otherwise payable under this Policy.

No benefit is payable for Paralysis if Paralysis is the result of a Critical Illness for which benefits are otherwise payable under this Policy.

With the exception of benefits that may be paid on behalf of a Covered Person in accordance with the Recurrence Benefit:

1. The sum of benefits paid for a Covered Person under each Category shall not exceed 100% of the Initial Benefit Amount for each Category; and

2. The sum of all benefits payable for a Covered Person under this Policy shall not exceed the Maximum Benefit Amount shown in the Policy schedule.

Benefits will not be paid for Critical Illnesses in more than a single Category during any 180-day period. However, this does not apply to multiple benefit payments for Critical Illnesses within the same category, unless the Initial Benefit Amount has been paid.

In the event benefits for a Covered Person are paid for a Critical Illness and within 180 days the Covered Person is Diagnosed with a Critical Illness from another Category with no benefit paid, any recurrence of the latter Critical Illness will be treated as an original Diagnosis with benefits paid accordingly.

If two or more Critical Illnesses are Diagnosed at the same proximate time, the benefit paid will be based upon the Diagnosed Critical Illness providing the largest benefit.

The Company will NOT pay benefits for a Critical Illness, if it is caused by or results from:

1. intentional self-inflicted injuries;

2. suicide, or any attempt at suicide, while sane or insane;

3. service in the armed forces or any auxiliary unit of the armed forces;

4. participation in the commission or attempted commission of a felony;

5. participation in a riot or insurrection;

6. alcoholism or drug addiction; or

7. being intoxicated or under the influence of alcohol, drugs, or any narcotic (including overdose) unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law and decisions of the jurisdiction in which the accident, cause of loss, or loss occurred.

The Company will NOT pay any benefit for a Critical Illness if:

1. A Critical Illness is Diagnosed outside the United States or a covered procedure is performed outside the United States.; or

2. the Covered Person's date of birth, age or sex was misstated on the Application and at the correct date of birth, age or sex the Policy would not have become effective or would have terminated.

PREEXISTING CONDITION LIMITATION. Critical Illness caused by or relating to a Preexisting Condition is not covered for the first 12 months after the Policy Date of each Covered Person.

ELIGIBILITY

FAMILY MEMBERS. The only members of Your family eligible for coverage under the Policy are You and Your eligible Dependents for which an Application and premium has been accepted by the Company. Each person

must be acceptable to the Company based on its rules in effect at the time of the Application for each person's coverage. Covered Persons as of the Policy Date are shown on the Policy Schedule of Benefits.

ADDITIONAL FAMILY MEMBERS. You may add eligible members of Your family to the Policy after the Policy Date with the consent of the Company. Evidence of eligibility and insurability satisfactory to the Company must be furnished. Each person must be acceptable to the Company based on its rules in effect at the time of the application for each person's coverage. The renewal premium for this Policy may be increased by the premium required for the new family member. The addition of the new family member will be shown by an endorsement to this Policy. The Policy Date with respect to the new family member will be the Policy Date shown on the endorsement.

NEWBORN CHILDREN. Your newborn child is automatically covered from the moment of birth until such child is 90 days old. Coverage for newborns shall be the same as for all other covered Dependent children. If You do not have other covered Dependents and desire uninterrupted coverage, at the end of the 90 day period, You will have the option to add Dependent child coverage to Your Policy. You must notify the Company in writing within 90 days of such birth and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 90 day period.

ADOPTED CHILDREN. An adopted child is automatically covered for the first 60 days from the date of the filing of a petition for adoption. Coverage is provided from the moment of birth if the petition for adoption and application for coverage is submitted to Us within 60 days after the birth. Coverage for such child will be the same as for all other covered Dependent children. If You do not have other covered Dependents and desire uninterrupted coverage, at the end of the 60 day period, You will have the option to add Dependent child coverage to Your Policy. You must notify the Company in writing within 60 days of the date of filing or from the date of birth and pay the required additional premium (if any), in order to have coverage for the adopted child continue beyond such 60 day period.

Coverage for a child that is placed with You for adoption will continue in accordance with the provisions of the Policy, unless the petition is denied prior to legal adoption and the child is removed from placement.

COURT ORDERED CUSTODY. We will not restrict or deny coverage due to the fact that: 1) a Dependent child does not reside with the noncustodial parent; or 2) the parent-child relationship was established through a paternity action; or 3) the minor child is covered through the state-administered Medicaid program; or 4) the minor child is not claimed as a dependent on the noncustodial parent's federal or state income tax return.

LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under this Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Policy Schedule and occurs on such date next following the date of the event that causes such termination.

RULES FOR ALL COVERED PERSONS - Coverage will end:

1. If this Policy is terminated in accordance with the section titled **TERMINATION OF COVERAGE**; or
2. If You fail to pay the required premium within the Grace Period.

RULES FOR ADULT COVERED PERSONS - Coverage will end:

1. For Your spouse if there is a divorce;
2. If a mentally or physically disabled covered Dependent marries or becomes capable of self-support; or
3. If Your spouse is not a Covered Person at the time of Your death, We will end coverage for all Covered Persons.

If You are married and die and Your spouse is a Covered Person, Your spouse will become the Policyholder. However, no change in such person’s benefit will occur without evidence of insurability acceptable to the Company.

RULES FOR CHILD COVERED PERSONS - Coverage will end for a child when:

1. The child is no longer a dependent of Yours;
2. The child gets married;

3. The child attains the Limiting Age, except for the extension allowed by the section titled **EXTENSION OF COVERAGE FOR SOME CHILDREN**; or
4. Neither You nor Your spouse remains covered under this Policy.

PREMIUM – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

EXTENSION OF COVERAGE FOR SOME CHILDREN

Coverage for a mentally or physically handicapped Dependent child that is covered under the Policy and who became incapacitated prior to their 26th birthday will not end when scheduled if the child depends on You for primary support and maintenance. Proof of the incapacity or dependency must be furnished to Us upon our request and at Our expense. The premium for such child's continued coverage will remain at the child rate until the child is no longer dependent or incapacitated. You must notify Us if the incapacity or dependency is removed or terminated.

TERMINATION OF COVERAGE

We can terminate a Covered Person's coverage under this Policy as of any of his/her premium due dates under any of the following conditions:

1. The Maximum Benefit Amount for such Covered Person has been paid;
2. Required premiums have not been paid in accordance with the terms of this Policy, or We have not received timely premium payments, subject to the Grace Period;
3. A Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of this Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under General Provisions; or
4. A Covered Person ceases to be eligible for continued coverage under this Policy as described in the section titled **LOSS OF ELIGIBILITY**.

CONVERSION PRIVILEGE

In certain cases, if coverage ends under this Policy a Covered Person may be able to buy a new Policy with the Company. We will issue it without regard to health status, but subject to the rules below:

WHO MAY CONVERT -- The following persons whose coverage has ended under this Policy, may buy a new Policy: (1) a child who is no longer considered an eligible Dependent; (2) a former spouse, if there is a legal divorce; or (3) in the event of Your death, a Covered Person listed in the Schedule of Benefits if Your spouse is a Covered Person.

WHAT MUST BE DONE -- Written application and the first premium payment for the conversion policy shall be made to the Company not later than thirty-one (31) days after such termination. The premium for the conversion policy shall be determined in accordance with Our table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

THE NEW POLICY -- The new Policy will be similar to this Policy at the option of the Company. Loss for which benefits may be paid under this Policy will not be covered under the new Policy. The new Policy that We normally issue in accordance with this part may not yet be approved for use in the place where the person lives. In that case, the Company will not be obliged to issue a new Policy.

The conversion policy will cover the Covered Persons on the date his/her coverage terminates under this Policy. At the option of the Company, a separate conversion policy may be issued to cover any dependent.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by this Policy; provided, however, that the conversion policy may provide for a reduction of its benefits by the amount of any such benefits payable under this Policy after the individual's insurance terminates.

WHEN NOT AVAILABLE -- This part will be of no effect as to any Covered Person if coverage ends because: (1) You fail to pay a premium in the time allowed; or (2) the date the Covered Person performs an act or practice that constitutes fraud, or are found to have made an intentional misrepresentation of material fact, relating in any way to the Policy, including claims for benefits under the Policy.

PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on Your premium class [and attained age]. We determine the premium class [and attained age] on each Premium Due Date. We will NOT CHANGE Your premium prior to Your first Policy anniversary, unless coverage changes. After Your first Policy anniversary, We may change premiums anytime, and from time to time, that We decide to change rates for persons in Your class [or based on Your attained age].

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis [or an attained age basis] as determined by Us. We will give You 60 days advance written notice before any premium change.

GRACE PERIOD -- There is a 31 day grace period for the payment of any premium. The Policy will stay in force during the 31 days. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which premium was paid.

PREMIUM REFUND AT DEATH -- If a Covered Person's coverage terminates due to death, the Company will refund the pro rata unearned portion of any premium paid beyond the end of the Policy month in which the death occurred. Unearned premiums will be paid in lump sum no later than thirty (30) days after We receive proof of such death.

CLAIM PROVISIONS

NOTICE OF CLAIM -- You must give the Company written notice of a claim. It should be given within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by You or on behalf of You or the Beneficiary to Us at our Home Office, or to any authorized agent of the Company, with information sufficient to identify You, will be deemed notice to the Company.

CLAIM FORMS -- The Company will send You a claim form when Your notice of claim is received. If the form is not furnished within 15 days from the time You give notice, You may fulfill the proof of loss requirements by sending written proof covering the occurrence, the character and the extent of the loss for which claim is made within the time set in Proof of Loss.

PROOF OF LOSS -- You must give the Company written proof of loss within 90 days after such loss. If it is not reasonably possible to do so, the Company will not reduce or deny Your claim for being late if proof is given as soon as reasonably possible. It must, however, be given within one year from the time otherwise required, unless You are not legally capable.

TIME OF PAYMENT OF CLAIMS -- All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid no less than 30 days from date of receipt of due written proof of loss and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof of loss.

PAYMENT OF CLAIMS -- All benefits due under the Policy will be paid to You, Your beneficiary or Your estate. If they are payable to Your estate, the Company may pay such benefits, up to an amount not to exceed $1,000, to any of Your relatives by blood or marriage who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision will fully discharge the Company to the extent of such payment.

ASSIGNMENT – A Policyholder may assign all of his or her rights, privileges and benefits under the Policy without the consent of his or her designated beneficiary. The Company is not bound by an assignment until the

Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

CHANGE OF BENEFICIARY -- Unless the Policyholder makes an irrevocable designation of Beneficiary, the right to change a Beneficiary is reserved for the Policyholder, and the consent of the Beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of Beneficiary or beneficiaries, or for any other changes in this Policy.

PHYSICAL EXAMINATIONS AND AUTOPSY -- The Company may have a Covered Person examined at its own expense as often as it may reasonably require while their claim is pending under this Policy and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS -- No action at law or in equity shall be brought to recover under the Policy for at least 60 days after You have given the Company written proof of loss in accordance with the requirements of the Policy. You cannot start such action more than 3 years after the date proof of loss is required to be furnished.

ILLEGAL OCCUPATION -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.

GENERAL PROVISIONS

ENTIRE CONTRACT -- The Entire Contract will consist of:

1. This Policy;
2. Your Application and attached papers; and
3. Any riders, endorsements or amendments issued with or added to this Policy.

We will deem all the statements provided in any attached Application and attached supplements, except fraudulent statements, as representations and not warranties.

We provide coverage described in this Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an executive officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of this Policy. Any changes must be attached to this Policy.

If the Policy is reinstated or renewed and the Policyholder or the beneficiary or assignee of the Policy makes a written request to Us for a copy of the application, We will within 30 days after receipt of the request at Our Home Office or any of Our branch offices deliver or mail to the person making the request a copy of the application. If the copy is not delivered or mailed after being requested, We will be precluded from introducing the application in evidence in any action or proceeding based upon or involving the Policy or it's reinstatement or renewal. In the case of a request from a beneficiary, the time within which We are required to furnish a copy of the application will not begin to run until after receipt of evidence satisfactory to Us of the beneficiary's vested interest in the Policy.

TIME LIMIT ON CERTAIN DEFENSES --

1. <u>MISSTATEMENTS IN THE APPLICATION</u> --
After 3 years from the Covered Person's Policy Date, We may only use fraudulent misstatements in such Covered Person's Application to void coverage under this Policy or to deny any claim under this Policy incurred after such 3 year period.

2. <u>PRE-EXISTING CONDITIONS</u> --
No benefit for Critical Illness First Occurring more than 12 months after a Covered Person's Policy Date will be reduced or denied because a medical condition related to a Critical Illness existed 12 months before the Covered Person's Policy Date.

REINSTATEMENT -- Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under this Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of this Policy, including **TIME LIMIT ON CERTAIN DEFENSES**. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers Critical Illness that First Occurs 10 days or more after the Covered Person's date of reinstatement**.**

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT YOU MAKE MORE THAN 180 DAYS AFTER YOUR COVERAGE UNDER THIS POLICY HAS TERMINATED.

NO ASSUMPTION OF LIABILITY -- Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no covered loss occurred; or
2. We determine that Our payment was erroneous or inappropriate.

MISSTATEMENTS OF AGE -- If a Covered Person has misstated his age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on such Covered Person's Policy Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

CONFORMITY WITH STATE STATUTES -- Any provision of this Policy which, on the Policy Date, is in conflict with the laws of the state in which You reside is amended to conform to the minimum requirements of the laws of such state.

CRITICAL ILLNESS INSURANCE POLICY

THIS IS A LIMITED BENEFIT HEALTH INSURANCE POLICY.

POLICIES OF THIS CATEGORY ARE DESIGNED TO PROVIDE LIMITED OR SUPPLEMENTAL BENEFITS. THIS POLICY DOES NOT PROVIDE FOR REIMBURSEMENT OF ANY MEDICAL EXPENSES. BENEFITS PROVIDED ARE A SUPPLEMENT, AND NOT INTENDED AS A SUBSTITUTE FOR MEDICAL EXPENSE COVERAGE OR DISABILITY INSURANCE. PLEASE READ THIS POLICY CAREFULLY.

Standard Life and Accident Insurance Company
A Member of the American National Family of Companies
Home Office: One Moody Plaza, Galveston, Texas, 77550
Toll-Free Telephone Number: 1-888-350-1488
(A Stock Insurance Company hereafter referred to as "Standard Life", "We", "Us", "Our" or "the Company")

MORTGAGE PROTECTION BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. This Rider is subject to all non-conflicting Policy provisions, terms, definitions and limitations. Unless otherwise indicated below, this Rider is effective on the Policy Date

Benefits provided by this Rider will not duplicate any similar benefits provided under the Policy.

CAUSAL CONDITION means a condition, listed in paragraph 1, below, of this Rider's BENEFIT provision, that is the direct cause, independent of any other cause, of Your Total Disability

TOTAL DISABILITY OR TOTALLY DISABLED means Your complete inability to engage in Your usual employment or occupation caused by You being Diagnosed with a Causal Condition that has left You mentally or physically incapacitated. Your **TOTAL DISABILITY** must begin within 12 months of the First Occurring Diagnosis of Your Causal Condition.

BENEFIT – Benefits under this Rider are payable when:

1. You have been Diagnosed as having any one of the following First Occurring Causal Conditions: Invasive Cancer; Heart Attack; Stroke; Major Organ Transplant; Coma; Paralysis; or Renal Failure; and

2. As a result of such condition, You are Totally Disabled for more than 30 days.

After You are Totally Disabled for more than 30 days, for each subsequent 30 day period You continue to be Totally Disabled, We will pay You Your selected monthly Mortgage Protection Benefit, shown in the Policy Schedule. If You have not been Totally Disabled for an entire subsequent 30 day period, the benefit payable will be prorated according to the total number of consecutive days the You were Totally Disabled during such period.

When You are no longer Totally Disabled as the result of the Causal Condition that led to any period of Total Disability, no further benefit will be paid. However, if You become Totally Disabled as the result of the same Causal Condition for which benefits were previously paid under this Rider, subsequent benefits will be paid from the first day of such subsequent Total Disability.

Total benefits paid under this Rider will not exceed this Rider's Maximum Rider Benefit, shown on Your Policy Schedule.

Any benefit payments under this Rider shall begin within 45 days following the Company's receipt of Your claim.

Mortgage Protection Benefit payments are provided only as the result of Your first Diagnosis of each Causal Condition, listed above, and Your resulting Total Disability; and does not apply to any claim made under the Recurrence benefit or a claim made by any other Covered Person.

Coverage under this Rider terminates on the first to occur of:

1. payment of the Maximum Rider Benefit; or

2. the date Your coverage under the Policy terminates

Rider Effective Date, if other than Policy Date: _____

Secretary

SLA-CIMP11

(SP FIELD - **MORTGAGE PROTECTION BENEFIT** – [$500 - $1500]
MAXIMUM RIDER BENEFIT - [$6,000 - $18,000**]**

Critical Illness

OUTLINE OF COVERAGE

POLICY FORM SERIES SLA-CI11

Standard Life and Accident Insurance Company
A Member of the American National Family of Companies

Mailing Address:
P.O. Box 696870
San Antonio, Texas 78269
Phone: 888.350.1488
(referred hereafter as "Standard Life", "we", "us", "our" or "the Company")

THIS IS LIMITED BENEFIT HEALTH INSURANCE.

THIS COVERAGE DOES NOT PROVIDE FOR REIMBURSEMENT OF ANY MEDICAL EXPENSES. BENEFITS PROVIDED ARE A SUPPLEMENT, AND NOT INTENDED AS A SUBSTITUTE FOR MEDICAL EXPENSE COVERAGE OR DISABILITY INSURANCE. PLEASE READ YOUR POLICY CAREFULLY.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, you should review the *Guide to Health Insurance for People with Medicare* available from the Company.

1. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Standard Life. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

   Critical Illness coverage is designed to provide, to persons insured, coverage in the form of a lump sum resulting from a covered diagnosed Critical Illness, subject to any limitations set forth in the policy.

2. **BENEFITS**

   Benefits paid on behalf of each Covered Person will not exceed the Maximum Benefit Amount which is three times the Initial Benefit Amount. Upon payment of the Maximum Benefit Amount on behalf of a Covered Person, coverage for such Covered Person will terminate.

   Benefits are payable under this policy for a Covered Person from each of the benefit categories shown in the policy schedule when such Covered Person is diagnosed with a Critical Illness. However, the total benefit payable under each category will not exceed the Initial Benefit Amount, also shown in the policy schedule.

   If the first benefit paid from a category is a 100% benefit, no further benefits for other Critical Illnesses under the same category will be paid. If the first benefit paid under a category is not a 100% benefit, subsequent benefits payable under the same category will be paid as a percentage of the initial benefit amount until the sum of all payments from that same category equals the Initial Benefit Amount. Then, no further benefits will be paid under that category, except as provided under the Recurrence Benefit.

   RECURRENCE BENEFIT – In addition to all other benefits otherwise paid under this policy, if a Category 2 and 3 Critical Illness for which a 100% benefit has been previously paid recurs more than 18 months following its first occurrence and prior to the total paid benefits exceeding the maximum benefit amount, we will pay a benefit of 25% of the initial benefit amount paid for up to two (2) such recurrences.

   However, for any benefit to be paid under this provision, coverage under this policy must be in effect for the Covered Person on the date recurrence is diagnosed and the Covered Person must have been treatment free (except for maintenance medication and follow-up visits) for 12 months prior to the recurrence.

   REDUCED BENEFIT PERIOD - If a Category 1 Critical Illness is diagnosed within 90 days of a Covered Person's policy date, the following Critical Illnesses will be limited to the respective maximum benefit percentage shown below. In addition, no other benefits for Category 1 Critical Illnesses will be paid.

   Invasive Cancer - 10%
   Cancer In Situ - 2.5%

   ADDITIONAL BENEFIT – If benefits under this policy are paid when you have been diagnosed as having any of the following Critical Illnesses: invasive cancer; heart attack; stroke; major organ failure; coma; or paralysis more than 90 days after your policy date, then an additional benefit equal to the value of 6 times the then current monthly premium for this policy will be paid to you.

   This additional benefit is provided only as the result of the first occurrence of your Critical Illness and does not apply to any claim made under the Recurrence Benefit or a claim made by any other Covered Person.

COVERED PERSON	BENEFIT AMOUNTS PER COVERED PERSON
Policyholder:	**Initial Benefit Amount**.....[$10,000 - $500,000]
Covered Spouse:	**Initial Benefit Amount**.....[$10,000 - $500,000]
Child:	**Initial Benefit Amount**.....[$10,000 - $30,000]
Maximum Benefit Amount:	3 times the Initial Benefit Amount

CATEGORY / CONDITION	BENEFIT PERCENTAGE
Category 1 Critical Illnesses:	
Invasive Cancer (Diagnosis more than [30, 90] days after policy Date)	100%
Invasive Cancer (Diagnosis during the first [30, 90] days of in force coverage)	10%
Cancer In Situ (Diagnosis more than [30, 90] days after policy Date)	25%
Cancer In Situ (Diagnosis during the first [30, 90] days of in force coverage)	2.5%
Category 2 Critical Illnesses:	
Heart Attack	100%
Stroke	100%
Heart Transplant or Combination Heart and Other Major Organ Transplant	100%
Coronary Artery Bypass Surgery	25%
Angioplasty	25%
Aortic Surgery	25%
Heart Valve Replacement/Repair Surgery	25%
Category 3 Critical Illnesses:	
Major Organ Transplant, not covered in Category 2	100%
Coma	100%
Paralysis	100%
End-Stage Renal Failure	100%

OPTIONAL MORTGAGE PROTECTION BENEFIT RIDER	BENEFIT AMOUNT
Mortgage Protection Benefit	[$500 - $1,500]
Maximum Rider Benefit	[$6,000 - $18,000]

After you are totally disabled for more than 30 days, for each subsequent 30 day period you continue to be totally disabled, we will pay your selected monthly Mortgage Protection Benefit, shown in the Policy Schedule. If you have not been totally disabled for an entire subsequent 30 day period, the benefit payable will be prorated according to the total number of consecutive days that you were totally disabled during such period.

3. **EXCEPTIONS, LIMITATIONS AND REDUCTIONS**

Benefits will not be paid for Critical Illnesses in more than a single category during any 180-day period. However, this does not apply to multiple benefit payments for Critical Illnesses within the same category, unless the initial benefit amount has been paid.

In the event benefits for a Covered Person are paid for a Critical Illness and within 180 days the Covered Person is diagnosed with a Critical Illness from another category with no benefit paid, any recurrence of the latter Critical Illness will be treated as an original diagnosis with benefits paid accordingly.

If two or more Critical Illnesses are diagnosed at the same proximate time, the benefit paid will be based upon the diagnosed Critical Illness providing the largest benefit.

The Company will NOT pay benefits for a Critical Illness, if it is caused by or results from:

1. Intentional self-inflicted injuries;
2. Suicide, or any attempt at suicide, while sane or insane;
3. Service in the armed forces or any auxiliary unit of the armed forces;
4. Participation in the commission or attempted commission of a felony;
5. Participation in a riot or insurrection;
6. Alcoholism or drug addiction; or
7. Being intoxicated or under the influence of alcohol, drugs, or any narcotic (including overdose) unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law and decisions of the jurisdiction in which the accident, cause of loss, or loss occurred.

Benefits otherwise payable are reduced 50% on the later of a Covered Person's age 70 or his/her 5th policy anniversary.

For a full list of Exceptions and Limitations refer to your policy.

PRE-EXISTING CONDITIONS – No benefit for Critical Illness first occurring more than 12 months after a Covered Person's policy date will be reduced or denied because a medical condition related to a Critical Illness existed 12 months before the Covered Person's policy date.

4. **GUARANTEED RENEWABLE AT THE OPTION OF THE POLICYHOLDER - SUBJECT TO PREMIUM IN EFFECT AT THE TIME OF RENEWAL.** You have the right to continue this policy in force subject to the termination provisions and your continued payment of premium in accordance with all the provisions of your policy.

5. **PREMIUMS**

Initial Premium: $[_____]

Mode of Payment Selected: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly PAC

Initial Modal Premium: $[_____]

Premiums are subject to change. The policy has a 31-day grace period.

This Outline is a brief description of the policy terms and provisions. Refer to the policy for further details.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION

You should carefully read Your Application and all documents attached to this Policy. Omissions or misstatements in Your Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage. Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Policy if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Application.

The Underwriting Department may be notified at the following address and phone number:

Health Underwriting
Standard Life and Accident Insurance Company
PO Box 696820
San Antonio, Texas 78269

Telephone: 1-888-350-1488

Your Application and all attached documents are part of this Policy. We provide coverage described in this Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete to the best of your knowledge and belief.

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Rate Information

Rate data applies to filing.

Filing Method:	Serff
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	05/04/2011
Filing Method of Last Filing:	New

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Standard Life and Accident Insurance Company	N/A	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 05/05/2011	Critical Illness Policy	SLA-CI11-AR	New		ATTAINED AGE RATES - CRITICAL ILLNESS POLICY.pdf ISSUE AGE RATES - CRITICAL ILLNESS POLICY - GENERIC.pdf
Approved-Closed 05/05/2011	Mortgage Protection Rider	SLA-CIMP11	New		MORTGAGE PROTECTION RIDER RATES - GENERIC.pdf

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Annual Premium Rates per 1000 of Initial benefit Amount

Policy Form SLA-CI11

Attained Age Rates

Attained Age	Initial Benefit Amount 10-50,000 (Simplified Underwriting)				Initial Benefit Amount 51-500,000 (Fully Underwritten)				Attained Age
	MNS	MSM	FNS	FSM	MNS	MSM	FNS	FSM	
18 - 24	$1.31	$1.88	$1.81	$3.71	$1.15	$1.70	$1.56	$3.28	**18 - 24**
25 - 29	$1.59	$2.38	$2.26	$4.62	$1.38	$2.09	$1.93	$4.06	**25 - 29**
30 - 34	$2.07	$3.63	$3.30	$6.12	$1.81	$3.22	$2.82	$5.39	**30 - 34**
35 - 39	$3.28	$5.64	$5.31	$8.46	$2.81	$4.90	$4.42	$7.30	**35 - 39**
40 - 44	$5.28	$9.26	$7.80	$11.53	$4.50	$7.95	$6.40	$9.82	**40 - 44**
45 - 49	$8.61	$15.41	$10.82	$15.68	$7.30	$13.17	$9.11	$13.29	**45 - 49**
50 - 54	$13.90	$25.31	$13.65	$21.27	$11.76	$21.53	$11.45	$17.99	**50 - 54**
55 - 59	$22.85	$37.43	$19.91	$30.52	$19.29	$31.68	$17.14	$25.76	**55 - 59**
60 - 64	$35.21	$50.75	$25.94	$41.92	$29.96	$44.07	$23.23	$35.65	**60 - 64**
65 - 69	$41.80	$68.81	$33.35	$55.67	$36.29	$60.13	$32.10	$50.25	**65 - 69**
70 - 74	$52.35	$89.33	$41.18	$77.07	$46.87	$88.52	$42.02	$81.07	**70 - 74**
75 - 79	$66.95	$127.39	$51.98	$109.90	$57.55	$123.66	$50.54	$111.33	**75 - 79**
80-84	$83.10	$162.72	$69.27	$143.58	$76.69	$161.55	$67.36	$145.45	**80 - 84**
85-89	$122.35	$229.58	$107.67	$198.07	$107.27	$200.59	$94.21	$180.59	**85 - 89**
90-94	$174.95	$302.58	$153.95	$266.97	$153.39	$264.36	$134.71	$243.41	**90 - 94**
95-100	$230.02	$432.01	$202.42	$372.72	$201.68	$377.45	$177.13	$339.82	**95 - 100**

Rate for all children: $3.25

A $25 annual policy fee is to be added to the final calculated rate

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Annual Premium Rates per 1000 of Initial benefit Amount

Policy Form SLA-CI11

Issue Age Rates

Issue Age	Initial Benefit Amount 10-50,000 (Simplified Underwriting)				Initial Benefit Amount 51-500,000 (Fully Underwritten)				Issue Age
	MNS	MSM	FNS	FSM	MNS	MSM	FNS	FSM	
18	3.50	5.10	4.64	7.00	3.26	4.83	4.33	6.51	18
19	3.50	5.10	4.64	7.00	3.26	4.83	4.33	6.51	19
20	3.50	5.10	4.64	7.00	3.26	4.83	4.33	6.51	20
21	3.50	5.10	4.64	7.00	3.26	4.83	4.33	6.51	21
22	3.50	5.10	4.64	7.00	3.26	4.83	4.33	6.51	22
23	3.78	5.54	4.88	7.31	3.50	5.22	4.53	6.77	23
24	4.06	5.98	5.12	7.62	3.74	5.60	4.74	7.04	24
25	4.33	6.43	5.37	7.94	3.99	5.99	4.94	7.30	25
26	4.61	6.87	5.61	8.25	4.23	6.37	5.15	7.57	26
27	4.89	7.31	5.85	8.56	4.47	6.76	5.35	7.83	27
28	5.28	7.91	6.22	9.06	4.83	7.31	5.68	8.29	28
29	5.67	8.51	6.58	9.56	5.19	7.86	6.01	8.76	29
30	6.07	9.12	6.95	10.07	5.56	8.42	6.34	9.22	30
31	6.46	9.72	7.31	10.57	5.92	8.97	6.67	9.69	31
32	6.85	10.32	7.68	11.07	6.28	9.52	7.00	10.15	32
33	7.44	11.21	8.17	11.79	6.79	10.29	7.41	10.76	33
34	8.04	12.10	8.66	12.52	7.29	11.06	7.81	11.37	34
35	8.63	12.99	9.15	13.24	7.80	11.82	8.22	11.97	35
36	9.23	13.88	9.64	13.97	8.30	12.59	8.62	12.58	36
37	9.82	14.77	10.13	14.69	8.81	13.36	9.03	13.19	37
38	10.58	15.90	10.63	15.52	9.46	14.33	9.45	13.89	38
39	11.34	17.03	11.14	16.35	10.12	15.31	9.86	14.59	39
40	12.11	18.16	11.64	17.17	10.77	16.28	10.28	15.29	40
41	12.87	19.29	12.15	18.00	11.43	17.26	10.69	15.99	41
42	13.63	20.42	12.65	18.83	12.08	18.23	11.11	16.69	42
43	14.65	21.93	13.30	20.07	12.97	19.56	11.67	17.77	43
44	15.67	23.44	13.95	21.31	13.86	20.89	12.24	18.85	44
45	16.69	24.95	14.61	22.55	14.75	22.22	12.80	19.92	45
46	17.71	26.46	15.26	23.79	15.64	23.55	13.37	21.00	46
47	18.73	27.97	15.91	25.03	16.53	24.88	13.93	22.08	47
48	19.93	29.73	16.68	26.51	17.58	26.41	14.59	23.37	48
49	21.13	31.49	17.45	27.99	18.63	27.95	15.26	24.67	49
50	22.34	33.24	18.22	29.47	19.68	29.48	15.92	25.96	50
51	23.54	35.00	18.99	30.95	20.73	31.02	16.59	27.26	51
52	24.74	36.76	19.76	32.43	21.78	32.55	17.25	28.55	52
53	25.89	38.60	20.63	34.13	22.78	34.14	17.99	30.03	53
54	27.04	40.44	21.49	35.84	23.78	35.72	18.73	31.51	54
55	28.20	42.29	22.36	37.54	24.79	37.31	19.47	33.00	55
56	29.35	44.13	23.22	39.25	25.79	38.89	20.21	34.48	56
57	30.50	45.97	24.09	40.95	26.79	40.48	20.95	35.96	57
58	31.64	48.03	24.89	43.21	27.94	42.50	21.83	37.74	58
59	32.79	50.09	25.68	45.47	29.09	44.51	22.72	39.53	59
60	33.93	52.14	26.48	47.73	30.24	46.53	23.60	41.31	60
61	35.08	54.20	27.27	49.99	31.39	48.54	24.49	43.10	61
62	36.22	56.26	28.07	52.25	32.54	50.56	25.37	44.88	62
63	37.77	59.95	29.96	54.67	34.86	56.00	27.97	49.48	63
64	39.32	63.63	31.86	57.09	37.19	61.43	30.56	54.07	64
65	40.87	67.32	33.75	59.51	39.51	66.87	33.16	58.67	65
66	42.42	71.00	35.65	61.93					66
67	43.97	74.69	37.54	64.35					67
68	46.77	79.54	39.42	69.09					68
69	49.57	84.39	41.30	73.84					69
70	52.38	89.25	43.19	78.58					70
71	55.18	94.10	45.07	83.33					71
72	57.98	98.95	46.95	88.07					72
73	60.96	106.63	49.39	94.32					73
74	63.94	114.32	51.83	100.56					74
75	66.93	122.00	54.26	106.81					75

Rate for all children:	$3.25

A $25 annual policy fee is to be added to the final calculated rate

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Annual Premium Rates per 1000 of Monthly benefit Amount

Mortgage Protection Rider SLA-CIMP11

Attained Age Rates

Attained Age	Initial Benefit Amount 10-50,000 (Simplified Underwriting)				Initial Benefit Amount 51-500,000 (Fully Underwritten)			
	MNS	MSM	FNS	FSM	MNS	MSM	FNS	FSM
18 - 24	$5.75	$7.48	$6.11	$10.53	$4.99	$6.64	$5.21	$9.19
25 - 29	$6.88	$9.31	$7.84	$13.98	$5.88	$8.03	$6.63	$12.10
30 - 34	$8.85	$14.20	$11.63	$19.40	$7.62	$12.33	$9.83	$16.78
35 - 39	$14.04	$22.50	$19.24	$28.14	$11.82	$19.09	$15.83	$23.79
40 - 44	$22.69	$37.72	$29.39	$39.90	$19.00	$31.61	$23.84	$33.29
45 - 49	$37.60	$64.58	$43.13	$56.33	$31.29	$53.84	$35.89	$46.74
50 - 54	$62.09	$109.18	$58.24	$80.89	$51.58	$90.59	$48.23	$66.82
55 - 59	$103.96	$162.23	$88.83	$119.96	$86.16	$133.87	$75.36	$98.62
60 - 64	$161.18	$216.02	$119.01	$167.78	$134.32	$182.40	$104.52	$138.22
65 - 69	$186.11	$279.45	$147.32	$216.73	$157.97	$236.87	$138.31	$188.59
70 - 74	$217.53	$333.26	$167.02	$279.38	$190.61	$320.30	$166.36	$283.31
75 - 79	$270.09	$455.08	$205.23	$387.21	$227.62	$428.76	$195.02	$378.51
80-84	$333.14	$580.05	$259.31	$483.49	$301.14	$557.35	$246.65	$473.19
85-89	$480.63	$805.54	$391.33	$654.23	$413.29	$681.85	$335.37	$577.08
90-94	$687.26	$1,061.67	$559.53	$881.81	$590.98	$898.62	$479.55	$777.82
95-100	$903.60	$1,515.81	$735.70	$1,231.11	$777.03	$1,283.03	$630.56	$1,085.90

Issue Age Rates

Issue Age	Initial Benefit Amount 10-50,000 (Simplified Underwriting)				Initial Benefit Amount 51-500,000 (Fully Underwritten)			
	MNS	MSM	FNS	FSM	MNS	MSM	FNS	FSM
18	15.38	20.28	15.67	19.88	14.14	18.86	14.47	18.24
19	15.38	20.28	15.67	19.88	14.14	18.86	14.47	18.24
20	15.38	20.28	15.67	19.88	14.14	18.86	14.47	18.24
21	15.38	20.28	15.67	19.88	14.14	18.86	14.47	18.24
22	15.38	20.28	15.67	19.88	14.14	18.86	14.47	18.24
23	16.53	21.95	16.59	21.08	15.12	20.28	15.25	19.26
24	17.69	23.61	17.52	22.28	16.10	21.70	16.03	20.28
25	18.84	25.28	18.45	23.49	17.08	23.12	16.81	21.30
26	20.00	26.94	19.37	24.69	18.06	24.54	17.59	22.32
27	21.16	28.61	20.30	25.89	19.05	25.96	18.38	23.35
28	22.78	30.96	21.66	27.73	20.53	28.06	19.58	25.00
29	24.41	33.31	23.01	29.57	22.01	30.16	20.79	26.65
30	26.04	35.66	24.37	31.41	23.49	32.26	21.99	28.30
31	27.67	38.01	25.72	33.25	24.97	34.36	23.19	29.95

32	29.30	40.36	27.08	35.09	26.45	36.46	24.40	31.60
33	31.85	44.07	29.00	37.84	28.58	39.58	25.99	33.88
34	34.39	47.78	30.93	40.60	30.70	42.70	27.58	36.15
35	36.94	51.49	32.85	43.35	32.82	45.81	29.17	38.43
36	39.48	55.20	34.78	46.11	34.94	48.93	30.76	40.70
37	42.03	58.91	36.71	48.86	37.06	52.05	32.34	42.98
38	45.34	63.77	38.90	52.12	39.85	56.14	34.15	45.70
39	48.65	68.62	41.09	55.38	42.64	60.22	35.96	48.41
40	51.96	73.47	43.29	58.64	45.43	64.31	37.77	51.13
41	55.27	78.32	45.48	61.90	48.22	68.40	39.58	53.85
42	58.58	83.18	47.67	65.16	51.02	72.48	41.39	56.57
43	63.23	89.98	50.82	70.12	54.98	78.33	44.08	60.79
44	67.87	96.79	53.97	75.07	58.95	84.17	46.78	65.00
45	72.51	103.60	57.12	80.02	62.92	90.01	49.48	69.22
46	77.15	110.41	60.27	84.97	66.89	95.86	52.18	73.44
47	81.79	117.22	63.42	89.92	70.86	101.70	54.88	77.65
48	87.54	125.49	67.59	96.60	75.79	108.75	58.43	83.33
49	93.28	133.76	71.77	103.28	80.73	115.80	61.99	89.01
50	99.03	142.03	75.95	109.96	85.66	122.85	65.55	94.69
51	104.77	150.30	80.13	116.64	90.60	129.90	69.11	100.36
52	110.52	158.58	84.30	123.32	95.53	136.95	72.66	106.04
53	116.17	166.71	88.94	130.85	100.36	143.77	76.55	112.37
54	121.82	174.85	93.57	138.38	105.18	150.59	80.44	118.69
55	127.47	182.98	98.21	145.90	110.01	157.42	84.33	125.02
56	133.12	191.11	102.84	153.43	114.83	164.24	88.22	131.34
57	138.77	199.25	107.48	160.95	119.66	171.06	92.11	137.67
58	144.18	207.29	111.74	170.59	124.90	178.70	96.52	144.94
59	149.58	215.34	116.00	180.22	130.15	186.34	100.93	152.20
60	154.99	223.38	120.26	189.85	135.40	193.98	105.33	159.47
61	160.39	231.43	124.52	199.49	140.64	201.62	109.74	166.74
62	165.80	239.48	128.78	209.12	145.89	209.26	114.15	174.01
63	171.79	252.25	136.19	217.40	154.59	227.32	123.72	189.40
64	177.79	265.02	143.60	225.68	163.29	245.37	133.30	204.80
65	183.78	277.79	151.01	233.96	171.99	263.42	142.88	220.20
66	189.77	290.56	158.42	242.24				
67	195.77	303.33	165.83	250.52				
68	204.80	316.49	170.75	264.27				
69	213.83	329.66	175.67	278.01				
70	222.86	342.82	180.59	291.76				
71	231.89	355.99	185.50	305.51				
72	240.92	369.15	190.42	319.25				
73	251.55	393.47	199.04	339.47				
74	262.18	417.78	207.65	359.68				
75	272.80	442.10	216.27	379.90				

Attained Age
18 - 24
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 - 64
65 - 69
70 - 74
75 - 79
80 - 84
85 - 89
90 - 94
95 - 100

Issue Age
18
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SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	05/05/2011

Comments:

Attachment:

AR Readability Certification SL.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	05/05/2011

Comments:

Attachments:

AR SL-CIINDAR2 APPLICATION.pdf

AR SL-CIINDSIAR2 APPLICATION.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	05/05/2011

Comments:

Attachment:

OUTLINE SLA-CI11OOC2 - OUTLINE - GENERIC.pdf

		Item Status:	Status Date:
Satisfied - Item:	PREVIOUSLY APPROVED DUPLICATION NOTICE	Approved-Closed	05/05/2011

Comments:

Attachment:

DUPLICATION NOTICE.pdf

Standard Life
AND ACCIDENT INSURANCE COMPANY
League City, Texas
A MEMBER OF THE AMERICAN NATIONAL FAMILY OF COMPANIES

READABILITY CERTIFICATION

We hereby certify that the following forms have achieved a Flesch scale readability score which meets the minimum reading ease score as required by your state:

SLA-CI11-AR
SLA-CI11OOC
SL-CIINDSIAR2
SL-CIINDAR2
SLA-CIMP11

William J. Hogan

Digitally signed by William J. Hogan
DN: cn=William J. Hogan, c=US, o=Standard Life and Accident Insurance Company, ou=Assistant Vice President, Health Compliance, email=william.hogan@anico.com
Date: 2011.05.04 13:32:10 -05'00'

William J. Hogan
Asst. Vice President, Health Compliance

05/04/2011

Date of Signature

Standard Life
A Member of the American National Family of Companies

Standard Life and Accident Insurance Company
Mailing Address: P.O. Box 696870, San Antonio, TX 78269
888.350.1488

CRITICAL ILLNESS INSURANCE APPLICATION

Please Print — Use Black Ink ❑ New Policy ❑ Reinstatement

SECTION A

1. Applicant _____ Date of Birth _____ Age ____ Sex ____ Height ____ Weight ____
Home Address _____ City _____ State ____ Zip _____
Phone (____) _____ Best time to call _____ ❑ a.m. ❑ p.m. Email _____
Social Security Number _____ Occupation _____
Billing Address (if different) _____ City _____ State ____ Zip _____

2. Please print the full name of all other Proposed Insureds (Use additional sheet and attach if needed).

Last, First, Middle Initial	Relationship	Sex M/F	Date of Birth Month, Day, Year	Age	Height (ft.-in.)	Weight (lbs.)	Occupation
	Spouse						

3. **BENEFIT AND PREMIUM DATA**

		Billable Premium
Applicant Benefit Amount:	$ _____	$ _____
Ages 65–70:	❑ $10,000 ❑ $15,000	$ _____
Ages 71–75:	❑ $10,000	$ _____
Spouse: (cannot be greater than the Applicant)	$ _____	$ _____
Child: (cannot be greater than the Applicant)	❑ $10,000 ❑ $15,000 ❑ $20,000 ❑ $25,000 ❑ $30,000	$ _____
Mortgage Protection Rider: (Applicant only–not available after age 65)	❑ $500 ❑ $1,000 ❑ $1,500	$ _____
Total Billable Premium:		$ _____

Billing Mode
❑ Annual
❑ Semi-Annual
❑ Quarterly
❑ Monthly PAC
❑ List Bill

4. Will any Critical Illness insurance be replaced with this policy? ..... ❑ **Yes** ❑ **No**
If Yes, which company? _____ Policy Number _____

SECTION B

5. Has the Applicant or any Proposed Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer or stroke? .. ❑ **Yes** ❑ **No**
If Yes, indicate family member, illness, age at onset of illness and, if applicable, age at death.

	Applicant		Spouse/Other Proposed Insured	
	Age if Living	Age at Death/Cause or Age at Diagnosis/Cause	Age if Living	Age at Death/Cause or Age at Diagnosis/Cause
Father				
Mother				
Sibling				

6. a. Has the Applicant used any form of tobacco within the past 12 months? ..... ❑ **Yes** ❑ **No**
b. Has the Spouse (if coverage applied for) used any form of tobacco within the past 12 months?..... ❑ **Yes** ❑ **No**
7. Has the Applicant or any Proposed Insured had a weight gain or loss of 10 pounds or more within the past 12 months? ..... ❑ **Yes** ❑ **No**
If Yes, provide name of Applicant or any Proposed Insured and details of weight change. ❑ Gain ❑ Loss
Name of Applicant or any Proposed Insured _____ Cause of Weight Gain/Loss _____
8. Does the Applicant or any Proposed Insured use a cane, walker, motorized vehicle, wheelchair or require mobility assistance by another person?..... ❑ **Yes** ❑ **No**
If Yes, provide details: _____
9. Has the Applicant or any Proposed Insured within the past 5 years been charged with a driving while impaired violation (alcohol, drugs, other), had driver's license revoked or suspended, or within the last 24 months received 3 or more citations for moving violations?..... ❑ **Yes** ❑ **No**
If Yes, provide driver's license number and state of issue: _____
10. Does the Applicant or any Proposed Insured intend to travel or reside outside the U.S. for more than 3 months during the next 12 months?..... ❑ **Yes** ❑ **No**
11. Within the past 5 years has the Applicant or any Proposed Insured:
a. had an application for insurance declined, rated or postponed?..... ❑ **Yes** ❑ **No**
b. flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so? ..... ❑ **Yes** ❑ **No**
c. engaged in boxing, scuba diving, parachuting, racing or any other hazardous sport or have intentions to do so? ..... ❑ **Yes** ❑ **No**
d. sought or received advice, counseling, or treatment by a physician for the use of alcohol or drugs including prescription drugs?. ❑ **Yes** ❑ **No**
e. used cocaine or marijuana or any other drug except as legally prescribed by a physician? ..... ❑ **Yes** ❑ **No**

SECTION B *(Continued)*

Please provide details for questions 10 and 11a through 11e.

Question	Name	Details

12. Has the Applicant or any Proposed Insured ever received treatment for, been diagnosed with, been advised to have diagnostic tests for, or is now being treated for any of the following:
    a. abnormal blood pressure, chest pain, coronary artery disease, abnormal ECG, elevated cholesterol, stroke, transient ischemic attack (TIA), peripheral vascular disease or any other disorder or disease or the heart, blood vessels or of the cerebrovascular system? ..... ❑ **Yes** ❑ **No**
    b. cancer, tumor, polyps, basal or squamous cell carcinoma, abnormal moles, or lesions, dysplastic nevi, malignant melanoma, abnormal PAP Smear, abnormal PSA test, abnormal mammogram, fibrocystic breast disease with history of breast biopsy, recurrent tumors or unexplained tumors or growth? ..... ❑ **Yes** ❑ **No**
    c. diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder? ..... ❑ **Yes** ❑ **No**
    d. any ear, nose, throat, lung, or any other respiratory disorder? ..... ❑ **Yes** ❑ **No**
    e. any disorder of the stomach, intestines, rectum, liver or pancreas? ..... ❑ **Yes** ❑ **No**
    f. any injury to or disease of the bones, muscles, joints, eyes, or skin? ..... ❑ **Yes** ❑ **No**
    g. epilepsy, seizures, brain disorder, tremor, multiple sclerosis, paralysis, Parkinson's, Alzheimer's or any other disease or disorder of the nervous system? ..... ❑ **Yes** ❑ **No**
    h. anxiety, depression, or an emotional, behavioral, mental or nervous disorder? ..... ❑ **Yes** ❑ **No**
    i. any disease or disorder of the kidney, bladder, or genital organs or system? ..... ❑ **Yes** ❑ **No**
    j. AIDS (Acquired Immune Deficiency syndrome), ARC (Aids Related Complex), positive HIV (Human Immunodeficiency Virus) test, or any other immunological disorder? ..... ❑ **Yes** ❑ **No**
13. Other than as stated above, has the Applicant or any Proposed Insured, within the past 5 years:
    a. consulted, received treatment or advice from, been prescribed medication by any other physician? ..... ❑ **Yes** ❑ **No**
    b. had any abnormal diagnostic or screening tests? ..... ❑ **Yes** ❑ **No**
    c. been aware of any symptoms for which a physician has not yet been consulted or been advised to have any diagnostic/screening or tests or procedures which have not yet been performed? ..... ❑ **Yes** ❑ **No**
14. Please list name and address of family/Primary Care Physician(s), reason and date last seen for each Applicant or any Proposed Insured including details for each Yes answer to questions 12 and 13.

Name of Applicant or any Proposed Insured	Condition	Medication	Date(s) of Treatment	Results	Name/Address of Physician

SECTION C

ATTENTION — After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I/we have received the *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare. I/We have also received an outline of coverage if required in my/our state.

FRAUD WARNING — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned has completed this application and represents that the answers and statements in Sections A and B on this application are true, complete, and correctly recorded to the best of my/our knowledge and belief; and agree they will be used to determine each Proposed Insured's eligibility for coverage applied for hereby. I/We understand and agree that: **1.** all statements and answers in this application and in any supplements or amendments to it are complete and true; **2.** any incorrect or incomplete information on this application may result in loss of coverage or claim denial; **3.** no insurance shall take effect unless a policy is issued (or if this application is made to change or reinstate an existing policy, unless the request is approved by the Company) and actually delivered to the Applicant and the first full premium paid during the lifetime and good health of all Proposed Insureds. I/We will notify and provide the Company with any evidence required by it to determine my/our future eligibility under the policy issued. If this application is taken over the phone, I/we agree that my/our electronic signature(s) serve(s) as my/our original signature(s).

I/We understand and agree that: 1. eligibility for the Plan does not constitute initial coverage under the Plan; and **2.** initial coverage under the Plan is subject to the Company's criteria.

This is a Limited Benefit Policy. Please review the policy carefully.

Date

Dated at City, State

Applicant's Signature

Spouse's Signature (if coverage is requested)

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I/We hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant or any Proposed Insured. It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I/We understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I/We understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I/We may refuse to sign this authorization and that my/our refusal to sign will affect my/our ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I/We, or my/our authorized representative, am/are entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I/We understand I/we may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I/We may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I/we agree that my/our electronic signature serves as my/our original signature.

Date	Dated at City, State
Applicant's Signature	Spouse's Signature (if coverage is requested)
Witness	Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other _____ .

AUTHORIZATION TO MY BANK

PREAUTHORIZED CHECK AUTHORIZATION

Attach Voided Check or Deposit Ticket Here and Sign Authorization

- ❑ **Checking**
- ❑ **Savings**

Bank Information

Name

City | State | Zip

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

Date Signed | ✓ Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number _____

Routing Number _____

AGENT STATEMENT

- As Agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? ..... ❑ **Yes** ❑ **No**
  If Yes, was a replacement form completed and a copy left with the Applicant? ..... ❑ **Yes** ❑ **No**
- As Agent, have you complied with state replacement regulations? ..... ❑ **Yes** ❑ **No**
- I have verified the Applicant's identity through a U.S. federal or state government-issued I.D. such as driver's license, government-issued I.D., passport, visa, etc. ..... ❑ **Yes** ❑ **No**

I have inquired about and have personal knowledge of the medical history of the Applicant and each Proposed Insured.

Agent's Name (please print) _____

Agent's Signature _____

Agent's Writing Number _____

Date Signed _____

Phone (_____) _____

Fax (_____) _____

Email _____

Premium Quoted: $_____

❑ **Premium collected with Application.**

❑ **Initial premium is to be drafted.**

Mail Policy to: ❑ Insured ❑ Agent

Special Request: _____

Standard Life
A Member of the American National Family of Companies

Standard Life and Accident Insurance Company
Mailing Address: P.O. Box 696870, San Antonio, TX 78269
888.350.1488

CRITICAL ILLNESS INSURANCE APPLICATION

Please Print — Use Black Ink ❑ New Policy ❑ Reinstatement

SECTION A

1. Applicant _____ Date of Birth _____ Age ____ Sex ____ Height ____ Weight ____

Home Address _____ City _____ State ____ Zip _____

Phone (____) _____ Best time to call _____ ❑ a.m. ❑ p.m. Email _____

Social Security Number _____ Occupation _____

Billing Address (if different) _____ City _____ State ____ Zip _____

2. Please print the full name of all other Proposed Insureds (Use additional sheet and attach if needed).

Last, First, Middle Initial	Relationship	Sex M/F	Date of Birth Month, Day, Year	Age	Height (ft.-in.)	Weight (lbs.)	Occupation
	Spouse						

3. **BENEFIT AND PREMIUM DATA** — **Billable Premium**

Applicant Benefit Amount:	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000	
	❑ $35,000	❑ $40,000	❑ $45,000	❑ $50,000		$ _____
Ages 65–70:	❑ $10,000	❑ $15,000				$ _____
Ages 71–75:	❑ $10,000					$ _____
Spouse: (cannot be greater than the Applicant)	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000	
	❑ $35,000	❑ $40,000	❑ $45,000	❑ $50,000		$ _____
Child: (cannot be greater than the Applicant)	❑ $10,000	❑ $15,000	❑ $20,000	❑ $25,000	❑ $30,000	$ _____
Mortgage Protection Rider: (Applicant only–not available after age 65)	❑ $500	❑ $1,000	❑ $1,500			$ _____
Total Billable Premium:						$ _____

Billing Mode
❑ Annual
❑ Semi-Annual
❑ Quarterly
❑ Monthly PAC
❑ List Bill

4. Will any Critical Illness insurance be replaced with this policy? ..... ❑ **Yes** ❑ **No**
If Yes, which company? _____ Policy Number _____

SECTION B (This plan cannot be issued to any person who answers Yes to questions 7, 8 or 9.)

5. Has the Applicant or any Proposed Insured had two or more biological parents and/or siblings, either living or deceased, diagnosed with or die from one of the same conditions listed below. If Yes, check all that apply and list name of Proposed Insured:

a. Prior to age 60		
❑ Cancer _____	❑ Heart Disease _____	❑ Stroke _____
❑ Diabetes _____	❑ Kidney Disease _____	
b. Prior to age 75		
❑ Alzheimer's _____	❑ Colorectal Cancer _____	❑ Senile Dementia _____

6. a. Has the Applicant used any form of tobacco within the past 12 months? ..... ❑ **Yes** ❑ **No**
b. Has the Spouse (if coverage applied for) used any form of tobacco within the past 12 months? ..... ❑ **Yes** ❑ **No**

7. In the past 2 years, has the Applicant or any Proposed Insured been informed by a physician of any abnormal test results or been advised to have any diagnostic/screening tests or procedures which have not yet been performed? ..... ❑ **Yes** ❑ **No**
If Yes, list name of Applicant or Proposed Insured: _____

8. Does the Applicant or any Proposed Insured use a cane, walker, motorized vehicle, wheelchair or require mobility assistance by another person? ..... ❑ **Yes** ❑ **No**
If Yes, list name of Applicant or Proposed Insured: _____

SECTION B *(Continued)*

9. Has the Applicant or Proposed Insured ever been diagnosed with, advised by a physician to have diagnostic tests for, been treated for in the past or is currently being treated for any of the following? ..... ❑ **Yes** ❑ **No**

If Yes, check all that apply and list name of Applicant or Proposed Insured:

- ❑ Alcohol or Drug Abuse _____
- ❑ Alzheimer's _____
- ❑ Angioplasty _____
- ❑ Aortic Surgery _____
- ❑ Bone Marrow Transplant _____
- ❑ Cancer (excluding non-invasive, non-melanoma Skin Cancer) _____
- ❑ Coronary Artery Bypass Surgery _____
- ❑ Diabetes _____
- ❑ End Stage Renal Disease _____
- ❑ Heart Attack _____
- ❑ Heart Valve Surgery _____
- ❑ Hepatitis B, C or Carrier _____
- ❑ Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) _____
- ❑ Leukemia _____
- ❑ Liver Cirrhosis _____
- ❑ Major Organ Failure or Transplant _____
- ❑ Multiple Sclerosis _____
- ❑ Senile Dementia _____
- ❑ Stroke _____
- ❑ Transient Ischemic Attack (TIA) _____

10. In the past 5 years, has the Applicant or any Proposed Insured been diagnosed with or treated for any of the following conditions? ❑ **Yes** ❑ **No**

If Yes, check all that apply:

- ❑ Abnormal Mammogram
- ❑ Abnormal Moles or Lesions
- ❑ Abnormal Pap Smear
- ❑ Abnormal Prostate-Specific Antigen (PSA)
- ❑ Basal or Squamous Cell Carcinoma
- ❑ Crohn's Disease (except irritable bowel disease or mucus colitis)
- ❑ Disease or disorder of the heart or blood vessels
- ❑ Disease of the nervous system (except non-chronic shingles)
- ❑ Dysplastic Nevi
- ❑ Fibrocystic Breast Disease (with history of biopsy)
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hyperlipidemia
- ❑ Kidney Disease (except non-chronic kidney stones or infection)
- ❑ Liver Disease
- ❑ Lung Disease (except asthma that has never required hospitalization and non-chronic bronchitis)
- ❑ Pancreas Disorder
- ❑ Polyps
- ❑ Pre-cancerous Lesions/ Tumors
- ❑ Recurrent Breast Tumors
- ❑ Recurrent Human Papilloma Virus (HPV)
- ❑ Skin Cancer
- ❑ Ulcerative Colitis
- ❑ Unexplained Tumors/ Growth

Complete the following for each condition checked in question 10.

Name of Applicant or Proposed Insured	Condition	Medication	Date(s) of Treatment	Results	Name/Address of Physician

SECTION C

ATTENTION — After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I/we have received the *Guide to Health Insurance for People with Medicare* and the Important Notice to Persons on Medicare. I/We have also received an outline of coverage if required in my/our state.

FRAUD WARNING — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application is guilty of a crime and may be subject to fines and confinement in prison.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned has completed this application and represents that the answers and statements in Sections A and B on this application are true, complete, and correctly recorded to the best of my/our knowledge and belief; and agree they will be used to determine each Proposed Insured's eligibility for coverage applied for hereby. I/We understand and agree that: **1.** all statements and answers in this application and in any supplements or amendments to it are complete and true; **2.** any incorrect or incomplete information on this application may result in loss of coverage or claim denial; **3.** no insurance shall take effect unless a policy is issued (or if this application is made to change or reinstate an existing policy, unless the request is approved by the Company) and actually delivered to the Applicant and the first full premium paid during the lifetime and good health of all Proposed Insureds. I/We will notify and provide the Company with any evidence required by it to determine my/our future eligibility under the policy issued. If this application is taken over the phone, I/we agree that my/our electronic signature(s) serve(s) as my/our original signature(s).

I/We understand and agree that: 1. eligibility for the Plan does not constitute initial coverage under the Plan; and **2.** initial coverage under the Plan is subject to the Company's criteria.

This is a Limited Benefit Policy. Please review the policy carefully.

Date _____ Dated at City, State _____

Applicant's Signature _____ Spouse's Signature (if coverage is requested) _____

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I/We hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Applicant or any Proposed Insured. It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I/We understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I/We understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I/We may refuse to sign this authorization and that my/our refusal to sign will affect my/our ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I/We, or my/our authorized representative, am/are entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I/We understand I/we may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I/We may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I/we agree that my/our electronic signature serves as my/our original signature.

Date	Dated at City, State
Applicant's Signature	Spouse's Signature (if coverage is requested)
Witness	Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian, guardian-in-fact, payee representative or other _____ .

AUTHORIZATION TO MY BANK

PREAUTHORIZED CHECK AUTHORIZATION

Attach Voided Check or Deposit Ticket Here and Sign Authorization

- ❑ **Checking**
- ❑ **Savings**

Bank Information

Name

City | State | Zip

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

Date Signed | ✓ Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number _____

Routing Number _____

AGENT STATEMENT

- As Agent, do you have knowledge or reason to believe that replacement of existing insurance may be involved? ..... ❑ **Yes** ❑ **No**
  If Yes, was a replacement form completed and a copy left with the Applicant? ..... ❑ **Yes** ❑ **No**
- As Agent, have you complied with state replacement regulations? ..... ❑ **Yes** ❑ **No**
- I have verified the Applicant's identity through a U.S. federal or state government-issued I.D. such as driver's license, government-issued I.D., passport, visa, etc. ..... ❑ **Yes** ❑ **No**

I have inquired about and have personal knowledge of the medical history of the Applicant and each Proposed Insured.

Agent's Name (please print) _____

Agent's Signature _____

Agent's Writing Number _____

Date Signed _____

Phone (_____) _____

Fax (_____) _____

Email _____

Premium Quoted: $_____

❑ **Premium collected with Application.**

❑ **Initial premium is to be drafted.**

Mail Policy to: ❑ Insured ❑ Agent

Special Request: _____

Critical Illness

OUTLINE OF COVERAGE

POLICY FORM SERIES SLA-CI11

Standard Life and Accident Insurance Company
A Member of the American National Family of Companies

Mailing Address:
P.O. Box 696870
San Antonio, Texas 78269
Phone: 888.350.1488
(referred hereafter as "Standard Life", "we", "us", "our" or "the Company")

THIS IS LIMITED BENEFIT HEALTH INSURANCE.

THIS COVERAGE DOES NOT PROVIDE FOR REIMBURSEMENT OF ANY MEDICAL EXPENSES. BENEFITS PROVIDED ARE A SUPPLEMENT, AND NOT INTENDED AS A SUBSTITUTE FOR MEDICAL EXPENSE COVERAGE OR DISABILITY INSURANCE. PLEASE READ YOUR POLICY CAREFULLY.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, you should review the *Guide to Health Insurance for People with Medicare* available from the Company.

1. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and Standard Life. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

   Critical Illness coverage is designed to provide, to persons insured, coverage in the form of a lump sum resulting from a covered diagnosed Critical Illness, subject to any limitations set forth in the policy.

2. **BENEFITS**

   Benefits paid on behalf of each Covered Person will not exceed the Maximum Benefit Amount which is three times the Initial Benefit Amount. Upon payment of the Maximum Benefit Amount on behalf of a Covered Person, coverage for such Covered Person will terminate.

   Benefits are payable under this policy for a Covered Person from each of the benefit categories shown in the policy schedule when such Covered Person is diagnosed with a Critical Illness. However, the total benefit payable under each category will not exceed the Initial Benefit Amount, also shown in the policy schedule.

   If the first benefit paid from a category is a 100% benefit, no further benefits for other Critical Illnesses under the same category will be paid. If the first benefit paid under a category is not a 100% benefit, subsequent benefits payable under the same category will be paid as a percentage of the initial benefit amount until the sum of all payments from that same category equals the Initial Benefit Amount. Then, no further benefits will be paid under that category, except as provided under the Recurrence Benefit.

   RECURRENCE BENEFIT – In addition to all other benefits otherwise paid under this policy, if a Category 2 and 3 Critical Illness for which a 100% benefit has been previously paid recurs more than 18 months following its first occurrence and prior to the total paid benefits exceeding the maximum benefit amount, we will pay a benefit of 25% of the initial benefit amount paid for up to two (2) such recurrences.

   However, for any benefit to be paid under this provision, coverage under this policy must be in effect for the Covered Person on the date recurrence is diagnosed and the Covered Person must have been treatment free (except for maintenance medication and follow-up visits) for 12 months prior to the recurrence.

   REDUCED BENEFIT PERIOD - If a Category 1 Critical Illness is diagnosed within 90 days of a Covered Person's policy date, the following Critical Illnesses will be limited to the respective maximum benefit percentage shown below. In addition, no other benefits for Category 1 Critical Illnesses will be paid.

   Invasive Cancer - 10%
   Cancer In Situ - 2.5%

   ADDITIONAL BENEFIT – If benefits under this policy are paid when you have been diagnosed as having any of the following Critical Illnesses: invasive cancer; heart attack; stroke; major organ failure; coma; or paralysis more than 90 days after your policy date, then an additional benefit equal to the value of 6 times the then current monthly premium for this policy will be paid to you.

   This additional benefit is provided only as the result of the first occurrence of your Critical Illness and does not apply to any claim made under the Recurrence Benefit or a claim made by any other Covered Person.

COVERED PERSON	BENEFIT AMOUNTS PER COVERED PERSON
Policyholder:	**Initial Benefit Amount**.....[$10,000 - $500,000]
Covered Spouse:	**Initial Benefit Amount**.....[$10,000 - $500,000]
Child:	**Initial Benefit Amount**.....[$10,000 - $30,000]
Maximum Benefit Amount:	3 times the Initial Benefit Amount

CATEGORY / CONDITION	BENEFIT PERCENTAGE
Category 1 Critical Illnesses:	
Invasive Cancer (Diagnosis more than [30, 90] days after policy Date)	100%
Invasive Cancer (Diagnosis during the first [30, 90] days of in force coverage)	10%
Cancer In Situ (Diagnosis more than [30, 90] days after policy Date)	25%
Cancer In Situ (Diagnosis during the first [30, 90] days of in force coverage)	2.5%
Category 2 Critical Illnesses:	
Heart Attack	100%
Stroke	100%
Heart Transplant or Combination Heart and Other Major Organ Transplant	100%
Coronary Artery Bypass Surgery	25%
Angioplasty	25%
Aortic Surgery	25%
Heart Valve Replacement/Repair Surgery	25%
Category 3 Critical Illnesses:	
Major Organ Transplant, not covered in Category 2	100%
Coma	100%
Paralysis	100%
End-Stage Renal Failure	100%

OPTIONAL MORTGAGE PROTECTION BENEFIT RIDER	BENEFIT AMOUNT
Mortgage Protection Benefit	[$500 - $1,500]
Maximum Rider Benefit	[$6,000 - $18,000]

After you are totally disabled for more than 30 days, for each subsequent 30 day period you continue to be totally disabled, we will pay your selected monthly Mortgage Protection Benefit, shown in the Policy Schedule. If you have not been totally disabled for an entire subsequent 30 day period, the benefit payable will be prorated according to the total number of consecutive days that you were totally disabled during such period.

3. **EXCEPTIONS, LIMITATIONS AND REDUCTIONS**

Benefits will not be paid for Critical Illnesses in more than a single category during any 180-day period. However, this does not apply to multiple benefit payments for Critical Illnesses within the same category, unless the initial benefit amount has been paid.

In the event benefits for a Covered Person are paid for a Critical Illness and within 180 days the Covered Person is diagnosed with a Critical Illness from another category with no benefit paid, any recurrence of the latter Critical Illness will be treated as an original diagnosis with benefits paid accordingly.

If two or more Critical Illnesses are diagnosed at the same proximate time, the benefit paid will be based upon the diagnosed Critical Illness providing the largest benefit.

The Company will NOT pay benefits for a Critical Illness, if it is caused by or results from:

1. Intentional self-inflicted injuries;
2. Suicide, or any attempt at suicide, while sane or insane;
3. Service in the armed forces or any auxiliary unit of the armed forces;
4. Participation in the commission or attempted commission of a felony;
5. Participation in a riot or insurrection;
6. Alcoholism or drug addiction; or
7. Being intoxicated or under the influence of alcohol, drugs, or any narcotic (including overdose) unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law and decisions of the jurisdiction in which the accident, cause of loss, or loss occurred.

Benefits otherwise payable are reduced 50% on the later of a Covered Person's age 70 or his/her 5th policy anniversary.

For a full list of Exceptions and Limitations refer to your policy.

PRE-EXISTING CONDITIONS – No benefit for Critical Illness first occurring more than 12 months after a Covered Person's policy date will be reduced or denied because a medical condition related to a Critical Illness existed 12 months before the Covered Person's policy date.

4. **GUARANTEED RENEWABLE AT THE OPTION OF THE POLICYHOLDER - SUBJECT TO PREMIUM IN EFFECT AT THE TIME OF RENEWAL.** You have the right to continue this policy in force subject to the termination provisions and your continued payment of premium in accordance with all the provisions of your policy.

5. **PREMIUMS**

Initial Premium: $[_____]

Mode of Payment Selected: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly PAC

Initial Modal Premium: $[_____]

Premiums are subject to change. The policy has a 31-day grace period.

This Outline is a brief description of the policy terms and provisions. Refer to the policy for further details.

Standard Life
A Member of the American National Family of Companies

Standard Life and Accident Insurance Company
Mailing Address: P.O. Box 696870, San Anonio, TX 78269
888.350.1488

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- Check the coverage in all health insurance policies you already have.
- For more information about long-term care insurance, review the *Shopper's Guide to Long-Term Care Insurance*, available from the insurance company.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance program.

SERFF Tracking Number:	*ANTX-127031871*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*48677*
Company Tracking Number:			
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*CRITICAL ILLNESS PRODUCT*		
Project Name/Number:	*CRITICAL ILLNESS PRODUCT/CRITICAL ILLNESS PRODUCT*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/04/2011	Form	Critical Illness Policy	05/05/2011	AR POLICY SLA-CI11 CRITICAL ILLNESS POLICY R Nonmkd.pdf (Superceded)

Standard Life and Accident Insurance Company

A Member of the American National Family of Companies
Home Office: One Moody Plaza, Galveston, Texas, 77550
Toll-Free Telephone Number: 1-888-350-1488
(A Stock Insurance Company hereafter referred to as "Standard Life", "We", "Us", "Our" or "the Company")

CRITICAL ILLNESS INSURANCE POLICY

We pay benefits in accordance with all the terms and conditions of this Policy when a Covered Person is Diagnosed with a Critical Illness. This Policy is a legal contract of insurance. This Policy is non-participating. **THIS POLICY PROVIDES NO BENEFITS OTHER THAN FOR A CRITICAL ILLNESS. READ IT CAREFULLY.**

CONSIDERATION - This Policy is issued in consideration of the statements made in the Application and payment of the Initial Premium. Coverage is not provided until the first full premium is paid. The first premium pays for the Initial Term of coverage. The Initial Term of coverage begins at 12:01 a.m. on the Policy Date shown in the Policy Schedule of Benefits. Coverage is continued in accordance with all of the provisions of this Policy.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION - You should carefully read Your Application and all documents attached to this Policy. Omissions or misstatements in Your Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage. Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Policy if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Application.

YOUR 30 DAY RIGHT TO EXAMINE POLICY. Within 30 days after You get this Policy, You may return it in person or by regular mail to the Company, its agency office or the agent who sold it to You, if for any reason You decide You do not want it. The Company will promptly return Your premium to You and then You and the Company will be in the same position as if a Policy had never been issued.

GUARANTEED RENEWABLE AT THE OPTION OF THE POLICYHOLDER – SUBJECT TO PREMIUM IN EFFECT AT THE TIME OF RENEWAL. You have the right to continue this Policy in force subject to the termination provisions and Your continued payment of premium in accordance with all the provisions of this Policy.

PREMIUMS ARE SUBJECT TO CHANGE - Please refer to the section titled **PREMIUMS**.

This Policy is signed below on behalf of Standard Life by its duly authorized officers.

Secretary

President

THIS IS A LIMITED BENEFIT HEALTH INSURANCE POLICY.

POLICIES OF THIS CATEGORY ARE DESIGNED TO PROVIDE LIMITED OR SUPPLEMENTAL BENEFITS. THIS POLICY DOES NOT PROVIDE FOR REIMBURSEMENT OF ANY MEDICAL EXPENSES. BENEFITS PROVIDED ARE A SUPPLEMENT, AND NOT INTENDED AS A SUBSTITUTE FOR MEDICAL EXPENSE COVERAGE OR DISABILITY INSURANCE. PLEASE READ THIS POLICY CAREFULLY!

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, You should review the *Guide To Health Insurance For People With Medicare* available from the Company.

TABLE OF CONTENTS

POLICY SCHEDULE

BENEFIT AMOUNTS PER COVERED PERSON

[BENEFITS OTHERWISE PAYABLE ARE REDUCED 50% ON THE LATER OF A COVERED PERSON'S AGE 70 OR HIS/HER 5TH POLICY ANNIVERSARY.]

POLICYHOLDER –
INITIAL BENEFIT AMOUNT – [$10,000 - $500,000]
MAXIMUM BENEFIT AMOUNT – 3 TIMES THE INITIAL BENEFIT AMOUNT

[SPOUSE -
INITIAL BENEFIT AMOUNT – [$10,000 - $500,000]
MAXIMUM BENEFIT AMOUNT – 3 TIMES THE INITIAL BENEFIT AMOUNT]

[CHILD –
INITIAL BENEFIT AMOUNT – [$10,000 - $500,000]
MAXIMUM BENEFIT AMOUNT – 3 TIMES THE INITIAL BENEFIT AMOUNT]

	BENEFIT PERCENTAGE
Category 1 Critical Illnesses -	
• Invasive Cancer (Diagnosis more than [30, 90] days after Policy Date)	100%
• Invasive Cancer (Diagnosis during the first [30, 90] days of in force coverage)	10%
• Cancer In Situ (Diagnosis more than [30, 90] days after Policy Date)	25%
• Cancer In Situ (Diagnosis during the first [30, 90] days of in force coverage)	2.5%
Category 2 Critical Illnesses -	
• Heart Attack	100%
• Stroke	100%
• Heart Transplant or Combination Heart and Other Major Organ Transplant	100%
• Coronary Artery Bypass Surgery	25%
• Angioplasty	25%
• Aortic Surgery	25%
• Heart Valve Replacement/Repair Surgery	25%
Category 3 Critical Illnesses -	
• Major Organ Transplant, not covered in Category 2	100%
• Coma	100%
• Paralysis	100%
• End-Stage Renal Failure	100%

OPTIONAL BENEFITS: [**None**] [**Mortgage Protection Benefit** – [$500 - $1500]
Maximum Rider Benefit - [$6,000 - $18,000]]

POLICY NUMBER – [xxxxxxxxxxxxx]

POLICY DATE – [MAY 1, 2010]

STATE OF ISSUE – ARKANSAS

INITIAL PREMIUM – [$xxxxx] A $25 annual policy fee is calculated into the annual premium.

INITIAL TERM – [ANNUAL, SEMI-ANNUAL, QUARTERLY, MONTHLY]

COVERED PERSONS	**RELATIONSHIP**	**AGE**	**DATE OF BIRTH**
[JJ ANICO	POLICYHOLDER	69	04/22/1942]
[GG ANICO	SPOUSE	24	04/16/1986]

[INTENTIONALLY LEFT BLANK]

DEFINITIONS

AGE means a Covered Person's age on his/her last birthday.

ANGIOPLASTY means the actual undergoing of a percutaneous transluminal angioplasty deemed Medically Necessary to correct a narrowing or blockage of one or more coronary arteries. A Physician, board-certified as a Cardiologist, must perform the Procedure. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

AORTIC SURGERY means the actual undergoing of surgery for disease of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. The surgery must be deemed Medically Necessary and performed by a Physician, board-certified as a cardiovascular surgeon, thoracic surgeon, or vascular surgeon. Aorta is limited to the thoracic and abdominal aorta, but not its branches.

CANCER IN SITU means a Diagnosis of Cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Cancer in Situ includes

1. early prostate cancer Diagnosed as T1N0M0 or equivalent staging; and
2. melanoma not invading the dermis.

Cancer in Situ does not include

1. other skin malignancies; or
2. pre-malignant lesions (such as intraepithelial neoplasia); or
3. benign tumors or polyps.

Cancer in Situ must be Diagnosed pursuant to a Pathological or Clinical Diagnosis.

CLINICAL DIAGNOSIS means a Diagnosis of Invasive Cancer or Cancer In Situ based on the study of symptoms and Diagnostic test results. We will accept a Clinical Diagnosis of Cancer only if the following conditions are met:

1. a Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
2. there is medical evidence to support the Diagnosis; and
3. a Physician is treating the Covered Person for Invasive Cancer and/or Cancer In Situ.

CLOSE RELATIVE means anyone related to a Covered Person by blood, marriage, or adoption; or a court appointed representative.

COMA means the diagnosis, by a Legally Qualified Physician board-certified as a Neurologist, that a Covered Person is in a state of unconsciousness:

1. from which he/she cannot be aroused;
2. in which external stimulation will produce no more than primitive avoidance reflexes; and
3. such state has persisted continuously for at least 96 hours.

No benefit is payable for Coma if Coma is the result of a Critical Illness for which benefits are otherwise payable under this Policy.

COVERED PERSON means each person named as a Covered Person on the Policy Schedule whose coverage under this Policy has not terminated.

CORONARY BYPASS SURGERY means the actual undergoing of coronary artery bypass surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease deemed Medically Necessary to correct a narrowing or blockage of one or more coronary arteries. The Procedure must be performed by a Physician, board-certified as a cardiovascular surgeon or thoracic surgeon. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.

CRITICAL ILLNESS means any of the medical conditions or procedures, shown in the Policy Schedule, that is first Diagnosed or first performed as the result of a Diagnosis, each made after the respective Covered Person's Policy Date.

DATE OF DIAGNOSIS means the date the Diagnosis is established by a Physician, through the use of clinical and/or laboratory findings as supported by the Covered Person's medical records. For a procedure, it is the date the Covered Person undergoes the procedure.

DEPENDENT means Policyholder's family as follows:
1. The lawful Spouse; or
2. Unmarried children (whether natural, adopted or stepchildren) under age 26; or
3. Unmarried children for whom the Policyholder is required to provide insurance under a medical support order or an order enforceable by a court; or
4. Unmarried children under the age of 26 that the Policyholder is seeking to adopt through an appropriate legal action before a court of competent jurisdiction over matters of adoption.

DIAGNOSIS - The definitive establishment by a Physician of the Critical Illness through the use of clinical and/or laboratory findings.

END-STAGE RENAL FAILURE means the chronic and irreversible failure of both of a Covered Person's kidneys, which requires the Covered Person to undergo periodic and ongoing dialysis. The Diagnosis must be made by a Physician.

FIRST OCCUR(S)/FIRST OCCURRING/FIRST OCCURRENCE means the occurrence, Diagnosis, or procedure is the first time ever in the Covered Person's lifetime that he/she has experienced such Critical Illness, been Diagnosed with that specific condition included as a Critical Illness, or undergone a specific procedure included as a Critical Illness.

HEART ATTACK means an Acute Myocardial Infarction resulting in:

1. the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries; and
2. resulting in the loss of the normal function of the heart.

The Diagnosis must be made by a Physician and based on both:

1. new clinical presentation and electrocardiographic changes consistent with an evolving heart attack; and
2. serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a Diagnosis of Heart Attack.

Established (old) Myocardial Infarction is excluded.

HEART VALVE REPLACEMENT/REPAIR SURGERY means the actual undergoing of open heart surgery to replace or repair one or more valves. The surgery must be deemed Medically Necessary and performed by a Physician, board-certified as a cardiovascular surgeon or thoracic surgeon.

INVASIVE CANCER means a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue through the basement membrane or capsule. "Invasive Cancer" includes, but shall not be limited to any form of:

1. Leukemia;
2. Lymphoma; or
3. Multiple Myeloma

The following are <u>not</u> "Invasive Cancer":
1. pre-malignant lesions (such as intraepithelial neoplasia); or
2. benign tumors or polyps; or
3. early prostate cancer Diagnosed as T1N0M0 or equivalent staging; or
4. Cancer in Situ; or
5. any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

Invasive Cancer must be Diagnosed by a by a Physician, board-certified as a pathologist pursuant to a Pathological or Clinical Diagnosis.

LIMITING AGE for Your children is 26 years of age.

MAJOR ORGAN means a Covered Person's entire liver, kidney, lung, heart, small intestine, pancreas, pancreas-kidney, bone marrow, or stem-cells. <u>No</u> other organ or system is included.

MAJOR ORGAN TRANSPLANT means the placement of an entire Major Organ in a Covered Person, where such Major Organ:

1. originates in a person other than such Covered Person;
2. is somewhat independent from all other parts of the human body; and
3. performs a special or unique function.

An Major Organ Transplant does not include the placement of a mechanical or man-made device or substance which is intended to serve as a substitute for or aid in the performance of the failed Major Organ; nor does it include Major Organ parts such as valves, ducts, arteries, and any other part of a Major Organ, which in and of itself provides no life sustaining purpose. For purposes of this definition, a Major Organ Transplant is considered to have occurred on the date a Covered Person is added to the United Network of Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP) transplant list.

MAXIMUM BENEFIT AMOUNT means the eligible total of Benefit Payments for all Critical Illnesses as stated in the Policy Schedule, including all components of the Multiple Payment Benefit provision. **RECURRENCE BENEFIT PAYMENTS ARE NOT INCLUDED IN THE MAXIMUM BENEFIT AMOUNT.**

MEDICALLY NECESSARY means that, based on generally accepted current medical practice, a service is necessary and appropriate for the Diagnosis or treatment of a Critical Illness. We do not consider a service Medically Necessary if:

1. It is provided only as a convenience to the Covered Person or provider; or
2. It is not appropriate treatment for the Covered Person's Diagnosis or symptoms;
3. It exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment.

PATHOLOGICAL DIAGNOSIS means Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.

PARALYSIS means a Covered Person's complete and permanent loss of use, not including amputation. of two or more limbs through neurological injury for a continuous period of at least 180 days, confirmed by a Legally Qualified Physician board-certified as a Neurologist. No benefit is payable for Paralysis if Paralysis is the result of a Critical Illness for which benefits are otherwise payable under this Policy.

PHYSICIAN means a person, other than You, a Close Relative, or a business or professional partner who is:

1. duly licensed to practice medicine in the jurisdiction where the Diagnosis is made, or the procedure performed where such jurisdiction is a continuing member of the United States of America or a territory within the jurisdiction of the United States of America (embassies, military zones, and similarly designated non-domestic extensions of the United States government are not included); and
2. acting within the scope of his/her license.

POLICY DATE means the date, shown in Your Policy Schedule, when coverage begins for the Covered Persons originally covered under this Policy. We use the Policy Date to determine the anniversary dates of coverage under this Policy. It also refers, separately, to the date We add a Covered Person to this Policy or when any change in coverage occurs.

POLICYHOLDER means You, the Applicant named in the attached Application, any successor thereof, or any person named to assume ownership privileges under this Policy after the original Policyholder's death. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

PREEXISTING CONDITION means a medical condition relating to a Critical Illness, not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Physician within 12 months before the Covered Person's Policy Date; or (2) that would have caused a reasonably prudent person to seek medical Diagnosis or treatment within 12 months before his/her Policy Date. Critical Illness related to such a medical condition is not covered within 12 months of a Covered Person's Policy Date

STROKE means any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent. Transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded. The Diagnosis must be made by a Physician.

US, WE, OUR or THE COMPANY means Standard Life and Accident Insurance Company (SLAICO).

YOU or YOUR means the Applicant, named in the attached Application who is the Policyholder.

BENEFIT

In accordance with all the terms and conditions of this Policy and upon Diagnosis providing evidence that a Covered Person has a Critical Illness First Occurring after the Covered Person's Policy Date, the Company will pay You the percentage of the Initial Benefit Amount shown in the Policy Schedule for the Diagnosed Critical Illness.

Benefits will be paid to You in a lump-sum. Benefits paid on behalf of each Covered Person will not exceed the Maximum Benefit Amount. Upon payment of the Maximum Benefit Amount on behalf of a Covered Person, coverage for such Covered Person will terminate.

Benefits are payable under this Policy for a Covered Person from each of the Benefit Categories shown in the Policy Schedule when such Covered Person is Diagnosed with a Critical Illness. However, the total benefit payable under each Category will not exceed the Initial Benefit Amount, also shown in the Policy Schedule.

If the first benefit paid from a Category is a 100% benefit, no further benefits for other Critical Illnesses under the same Category will be paid. If the first benefit paid under a Category is not a 100% benefit, subsequent benefits payable under the same Category will be paid as a percentage of the Initial Benefit Amount until the sum of all payments from that same Category equals the Initial Benefit Amount. Then, no further benefits will be paid under that Category, except as provided under the Recurrence Benefit.

RECURRENCE BENEFIT – In addition to all other benefits otherwise paid under this Policy, if a Category 2 & 3 Critical Illness for which a 100% benefit has been previously paid recurs more than 18 months following its First Occurrence and prior to the total paid benefits exceeding the Maximum Benefit Amount, We will pay a benefit of 25% of the Initial Benefit Amount paid for up to two (2) such recurrences.

However, for any benefit to be paid under this provision, coverage under this Policy must be in effect for the Covered Person on the date recurrence is Diagnosed and the Covered Person must have been treatment free (except for maintenance medication and follow-up visits) for 12 months prior to the recurrence.

REDUCED BENEFIT PERIOD - If a Category 1 Critical Illness is Diagnosed within [30 – 90] days of a Covered Person's Policy Date, the following Critical Illnesses will be limited to the respective maximum benefit percentage shown below. In addition, no other benefits for Category 1 Critical Illnesses will be paid.

Invasive Cancer - 10%
Cancer In Situ - 2.5%

ADDITIONAL BENEFIT – If benefits under this Policy are paid when You have been Diagnosed as having any of the following Critical Illnesses: Invasive Cancer; Heart Attack; Stroke; Major Organ Failure; Coma; or Paralysis, more than 90 days after Your Policy Date, then an additional benefit equal to the value of 6 times the then current monthly premium for this Policy will be paid to You.

This Additional Benefit is provided only as the result of the First Occurrence of Your Critical Illness and does not apply to any claim made under the Recurrence Benefit or a claim made by any other Covered Person.

EXCEPTIONS and LIMITATIONS

[Benefits otherwise payable under the Policy are reduced 50% on the later of a Covered Person's Age 70 or his/her 5th Policy anniversary.]

Unless the Covered Person's Critical Illness First Occurs or is Diagnosed while coverage is in force under this Policy, no benefit will be payable.

No benefit is payable for Coma if Coma is the result of a Critical Illness for which benefits are otherwise payable under this Policy.

No benefit is payable for Paralysis if Paralysis is the result of a Critical Illness for which benefits are otherwise payable under this Policy.

With the exception of benefits that may be paid on behalf of a Covered Person in accordance with the Recurrence Benefit:

1. The sum of benefits paid for a Covered Person under each Category shall not exceed 100% of the Initial Benefit Amount for each Category; and

2. The sum of all benefits payable for a Covered Person under this Policy shall not exceed the Maximum Benefit Amount shown in the Policy schedule.

Benefits will not be paid for Critical Illnesses in more than a single Category during any 180-day period. However, this does not apply to multiple benefit payments for Critical Illnesses within the same category, unless the Initial Benefit Amount has been paid.

In the event benefits for a Covered Person are paid for a Critical Illness and within 180 days the Covered Person is Diagnosed with a Critical Illness from another Category with no benefit paid, any recurrence of the latter Critical Illness will be treated as an original Diagnosis with benefits paid accordingly.

If two or more Critical Illnesses are Diagnosed at the same proximate time, the benefit paid will be based upon the Diagnosed Critical Illness providing the largest benefit.

The Company will NOT pay benefits for a Critical Illness, if it is caused by or results from:

1. intentional self-inflicted injuries;

2. suicide, or any attempt at suicide, while sane or insane;

3. service in the armed forces or any auxiliary unit of the armed forces;

4. participation in the commission or attempted commission of a felony;

5. participation in a riot or insurrection;

6. alcoholism or drug addiction; or

7. being intoxicated or under the influence of alcohol, drugs, or any narcotic (including overdose) unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law and decisions of the jurisdiction in which the accident, cause of loss, or loss occurred.

The Company will NOT pay any benefit for a Critical Illness if:

1. A Critical Illness is Diagnosed outside the United States or a covered procedure is performed outside the United States.; or

2. the Covered Person's date of birth, age or sex was misstated on the Application and at the correct date of birth, age or sex the Policy would not have become effective or would have terminated.

PREEXISTING CONDITION LIMITATION. Critical Illness caused by or relating to a Preexisting Condition is not covered for the first 12 months after the Policy Date of each Covered Person.

ELIGIBILITY

FAMILY MEMBERS. The only members of Your family eligible for coverage under the Policy are You and Your eligible Dependents for which an Application and premium has been accepted by the Company. Each person

must be acceptable to the Company based on its rules in effect at the time of the Application for each person's coverage. Covered Persons as of the Policy Date are shown on the Policy Schedule of Benefits.

ADDITIONAL FAMILY MEMBERS. You may add eligible members of Your family to the Policy after the Policy Date with the consent of the Company. Evidence of eligibility and insurability satisfactory to the Company must be furnished. Each person must be acceptable to the Company based on its rules in effect at the time of the application for each person's coverage. The renewal premium for this Policy may be increased by the premium required for the new family member. The addition of the new family member will be shown by an endorsement to this Policy. The Policy Date with respect to the new family member will be the Policy Date shown on the endorsement.

NEWBORN CHILDREN. Your newborn child is automatically covered from the moment of birth until such child is 90 days old. Coverage for newborns shall be the same as for all other covered Dependent children. If You do not have other covered Dependents and desire uninterrupted coverage, at the end of the 90 day period, You will have the option to add Dependent child coverage to Your Policy. You must notify the Company in writing within 90 days of such birth and pay the required additional premium (if any), in order to have coverage for the newborn child continue beyond such 90 day period.

ADOPTED CHILDREN. An adopted child is automatically covered for the first 60 days from the date of the filing of a petition for adoption. Coverage is provided from the moment of birth if the petition for adoption and application for coverage is submitted to Us within 60 days after the birth. Coverage for such child will be the same as for all other covered Dependent children. If You do not have other covered Dependents and desire uninterrupted coverage, at the end of the 60 day period, You will have the option to add Dependent child coverage to Your Policy. You must notify the Company in writing within 60 days of the date of filing or from the date of birth and pay the required additional premium (if any), in order to have coverage for the adopted child continue beyond such 60 day period.

Coverage for a child that is placed with You for adoption will continue in accordance with the provisions of the Policy, unless the petition is denied prior to legal adoption and the child is removed from placement.

COURT ORDERED CUSTODY. We will not restrict or deny coverage due to the fact that: 1) a Dependent child does not reside with the noncustodial parent; or 2) the parent-child relationship was established through a paternity action; or 3) the minor child is covered through the state-administered Medicaid program; or 4) the minor child is not claimed as a dependent on the noncustodial parent's federal or state income tax return.

LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under this Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Policy Schedule and occurs on such date next following the date of the event that causes such termination.

RULES FOR ALL COVERED PERSONS - Coverage will end:

1. If this Policy is terminated in accordance with the section titled **TERMINATION OF COVERAGE**; or
2. If You fail to pay the required premium within the Grace Period.

RULES FOR ADULT COVERED PERSONS - Coverage will end:

1. For Your spouse if there is a divorce;
2. If a mentally or physically disabled covered Dependent marries or becomes capable of self-support; or
3. If Your spouse is not a Covered Person at the time of Your death, We will end coverage for all Covered Persons.

If You are married and die and Your spouse is a Covered Person, Your spouse will become the Policyholder. However, no change in such person’s benefit will occur without evidence of insurability acceptable to the Company.

RULES FOR CHILD COVERED PERSONS - Coverage will end for a child when:

1. The child is no longer a dependent of Yours;
2. The child gets married;

3. The child attains the Limiting Age, except for the extension allowed by the section titled **EXTENSION OF COVERAGE FOR SOME CHILDREN**; or
4. Neither You nor Your spouse remains covered under this Policy.

PREMIUM – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

EXTENSION OF COVERAGE FOR SOME CHILDREN

When a dependent child who is a Covered Person reaches the Limiting Age, coverage may continue if the child is, and remains, incapable of self-sustaining employment, by reason of mental or physical handicap, and is chiefly dependent upon You for support and maintenance. The child will continue as a Covered Person if You:

1. Send written proof of the child's incapacity no later than 31 days after the premium due date which coincides with or next follows the child's attainment of the Limiting Age;
2. Furnish, upon request, proof of the child's incapacity and dependency during the two years following the child's attainment of limiting age;
3. Furnish proof of the child's incapacity and dependency once a year after the two-year period described in 2 above; and
4. Pay the premium for the child. This will be on the same basis as that for an adult of like age and sex.

TERMINATION OF COVERAGE

We can terminate a Covered Person's coverage under this Policy as of any of his/her premium due dates under any of the following conditions:

1. The Maximum Benefit Amount for such Covered Person has been paid;
2. Required premiums have not been paid in accordance with the terms of this Policy, or We have not received timely premium payments, subject to the Grace Period;
3. A Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of this Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under General Provisions; or
4. A Covered Person ceases to be eligible for continued coverage under this Policy as described in the section titled **LOSS OF ELIGIBILITY**.

CONVERSION PRIVILEGE

In certain cases, if coverage ends under this Policy a Covered Person may be able to buy a new Policy with the Company. We will issue it without regard to health status, but subject to the rules below:

WHO MAY CONVERT -- The following persons whose coverage has ended under this Policy, may buy a new Policy: (1) a child who is no longer considered an eligible Dependent; (2) a former spouse, if there is a legal divorce; or (3) in the event of Your death, a Covered Person listed in the Schedule of Benefits if Your spouse is a Covered Person.

WHAT MUST BE DONE -- Written application and the first premium payment for the conversion policy shall be made to the Company not later than thirty-one (31) days after such termination. The premium for the conversion policy shall be determined in accordance with Our table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

THE NEW POLICY -- The new Policy will be similar to this Policy at the option of the Company. Loss for which benefits may be paid under this Policy will not be covered under the new Policy. The new Policy that We normally issue in

accordance with this part may not yet be approved for use in the place where the person lives. In that case, the Company will not be obliged to issue a new Policy.

The conversion policy will cover the Covered Persons on the date his/her coverage terminates under this Policy. At the option of the Company, a separate conversion policy may be issued to cover any dependent.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by this Policy; provided, however, that the conversion policy may provide for a reduction of its benefits by the amount of any such benefits payable under this Policy after the individual's insurance terminates.

WHEN NOT AVAILABLE -- This part will be of no effect as to any Covered Person if coverage ends because: (1) You fail to pay a premium in the time allowed; or (2) the date the Covered Person performs an act or practice that constitutes fraud, or are found to have made an intentional misrepresentation of material fact, relating in any way to the Policy, including claims for benefits under the Policy.

PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on Your premium class [and attained age]. We determine the premium class [and attained age] on each Premium Due Date. We will NOT CHANGE Your premium prior to Your first Policy anniversary, unless coverage changes. After Your first Policy anniversary, We may change premiums anytime, and from time to time, that We decide to change rates for persons in Your class [or based on Your attained age].

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis [or an attained age basis] as determined by Us. We will give You 60 days advance written notice before any premium change.

GRACE PERIOD -- There is a 31 day grace period for the payment of any premium. The Policy will stay in force during the 31 days. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which premium was paid.

PREMIUM REFUND AT DEATH -- If a Covered Person's coverage terminates due to death, the Company will refund the pro rata unearned portion of any premium paid beyond the end of the Policy month in which the death occurred. Unearned premiums will be paid in lump sum no later than thirty (30) days after We receive proof of such death.

CLAIM PROVISIONS

NOTICE OF CLAIM -- You must give the Company written notice of a claim. It should be given within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by You or on behalf of You or the Beneficiary to Us at our Home Office, or to any authorized agent of the Company, with information sufficient to identify You, will be deemed notice to the Company.

CLAIM FORMS -- The Company will send You a claim form when Your notice of claim is received. If the form is not furnished within 15 days from the time You give notice, You may fulfill the proof of loss requirements by sending written proof covering the occurrence, the character and the extent of the loss for which claim is made within the time set in Proof of Loss.

PROOF OF LOSS -- You must give the Company written proof of loss within 90 days after such loss. If it is not reasonably possible to do so, the Company will not reduce or deny Your claim for being late if proof is given as soon as reasonably possible. It must, however, be given within one year from the time otherwise required, unless You are not legally capable.

TIME OF PAYMENT OF CLAIMS -- All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid no less than 30 days from date of receipt of due written proof of loss and any balance

remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof of loss.

PAYMENT OF CLAIMS -- All benefits due under the Policy will be paid to You, Your beneficiary or Your estate. If they are payable to Your estate, the Company may pay such benefits, up to an amount not to exceed $1,000, to any of Your relatives by blood or marriage who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision will fully discharge the Company to the extent of such payment.

ASSIGNMENT – A Policyholder may assign all of his or her rights, privileges and benefits under the Policy without the consent of his or her designated beneficiary. The Company is not bound by an assignment until the Company receives and files a signed copy. The Company is not responsible for the validity of assignments. The assignee only takes such rights as the assignor possessed and such rights are subject to state and federal laws and the terms of the Policy.

CHANGE OF BENEFICIARY -- Unless the Policyholder makes an irrevocable designation of Beneficiary, the right to change a Beneficiary is reserved for the Policyholder, and the consent of the Beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of Beneficiary or beneficiaries, or for any other changes in this Policy.

PHYSICAL EXAMINATIONS AND AUTOPSY -- The Company may have a Covered Person examined at its own expense as often as it may reasonably require while their claim is pending under this Policy and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS -- No action at law or in equity shall be brought to recover under the Policy for at least 60 days after You have given the Company written proof of loss in accordance with the requirements of the Policy. You cannot start such action more than 3 years after the date proof of loss is required to be furnished.

ILLEGAL OCCUPATION -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.

GENERAL PROVISIONS

ENTIRE CONTRACT -- The Entire Contract will consist of:

1. This Policy;
2. Your Application and attached papers; and
3. Any riders, endorsements or amendments issued with or added to this Policy.

We will deem all the statements provided in any attached Application and attached supplements, except fraudulent statements, as representations and not warranties.

We provide coverage described in this Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an executive officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of this Policy. Any changes must be attached to this Policy.

If the Policy is reinstated or renewed and the Policyholder or the beneficiary or assignee of the Policy makes a written request to Us for a copy of the application, We will within 30 days after receipt of the request at Our Home Office or any of Our branch offices deliver or mail to the person making the request a copy of the application. If the copy is not delivered or mailed after being requested, We will be precluded from introducing the application in evidence in any action or proceeding based upon or involving the Policy or it's reinstatement or renewal. In the case of a request from a beneficiary, the time within which We are required to furnish a copy of the application will not begin to run until after receipt of evidence satisfactory to Us of the beneficiary's vested interest in the Policy.

TIME LIMIT ON CERTAIN DEFENSES --

1. <u>MISSTATEMENTS IN THE APPLICATION</u> --
After 3 years from the Covered Person's Policy Date, We may only use fraudulent misstatements in such Covered Person's Application to void coverage under this Policy or to deny any claim under this Policy incurred after such 3 year period.

2. PRE-EXISTING CONDITIONS --
No benefit for Critical Illness First Occurring more than 12 months after a Covered Person's Policy Date will be reduced or denied because a medical condition related to a Critical Illness existed 12 months before the Covered Person's Policy Date.

REINSTATEMENT -- Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under this Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of this Policy, including **TIME LIMIT ON CERTAIN DEFENSES**. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers Critical Illness that First Occurs 10 days or more after the Covered Person's date of reinstatement**.**

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT YOU MAKE MORE THAN 180 DAYS AFTER YOUR COVERAGE UNDER THIS POLICY HAS TERMINATED.

NO ASSUMPTION OF LIABILITY -- Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no covered loss occurred; or
2. We determine that Our payment was erroneous or inappropriate.

MISSTATEMENTS OF AGE -- If a Covered Person has misstated his age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on such Covered Person's Policy Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

CONFORMITY WITH STATE STATUTES -- Any provision of this Policy which, on the Policy Date, is in conflict with the laws of the state in which You reside is amended to conform to the minimum requirements of the laws of such state.

CRITICAL ILLNESS INSURANCE POLICY

THIS IS A LIMITED BENEFIT HEALTH INSURANCE POLICY.

POLICIES OF THIS CATEGORY ARE DESIGNED TO PROVIDE LIMITED OR SUPPLEMENTAL BENEFITS. THIS POLICY DOES NOT PROVIDE FOR REIMBURSEMENT OF ANY MEDICAL EXPENSES. BENEFITS PROVIDED ARE A SUPPLEMENT, AND NOT INTENDED AS A SUBSTITUTE FOR MEDICAL EXPENSE COVERAGE OR DISABILITY INSURANCE. PLEASE READ THIS POLICY CAREFULLY.